JOURNAL

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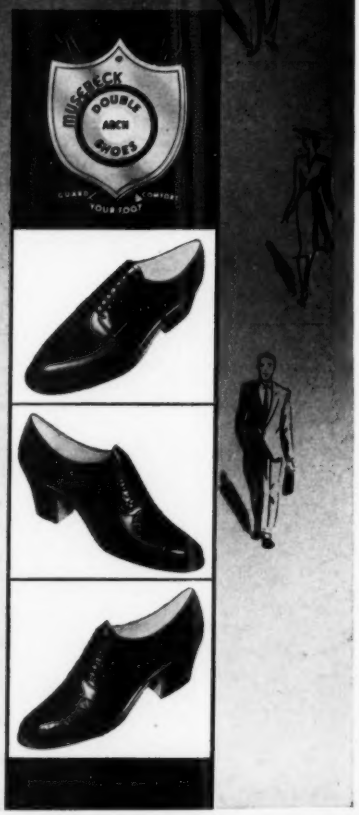

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The Official Publication of the Podiatry-Chiropody Profession
Published under direction of the Board of Trustees

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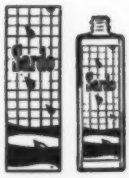

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of the
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PODIATRY
ASSOCIATION

The Official Publication
of the
Podiatry-Chiropody Profession
3301 16th Street, N. W.
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NOrth 7-4587

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The *Journal of the American Podiatry Association* is published monthly and copyrighted in 1959 by the American Podiatry Association.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879, re-entered March 3, 1958. Publication office, 375 Broadway, Boston, and Editorial Executive offices, 3301 16th St., N.W., Washington 10, D. C.

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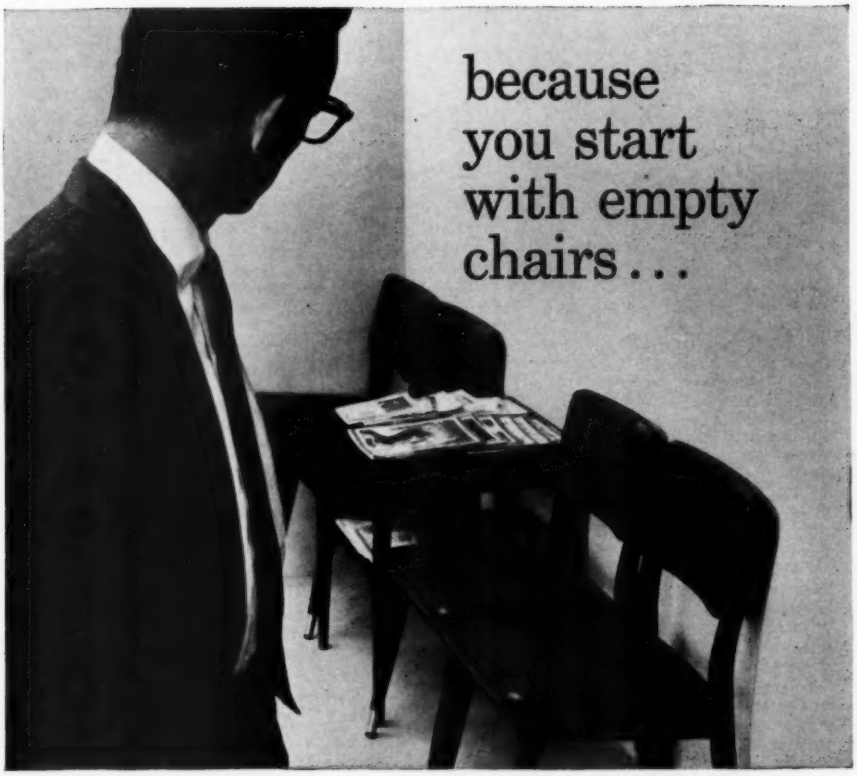

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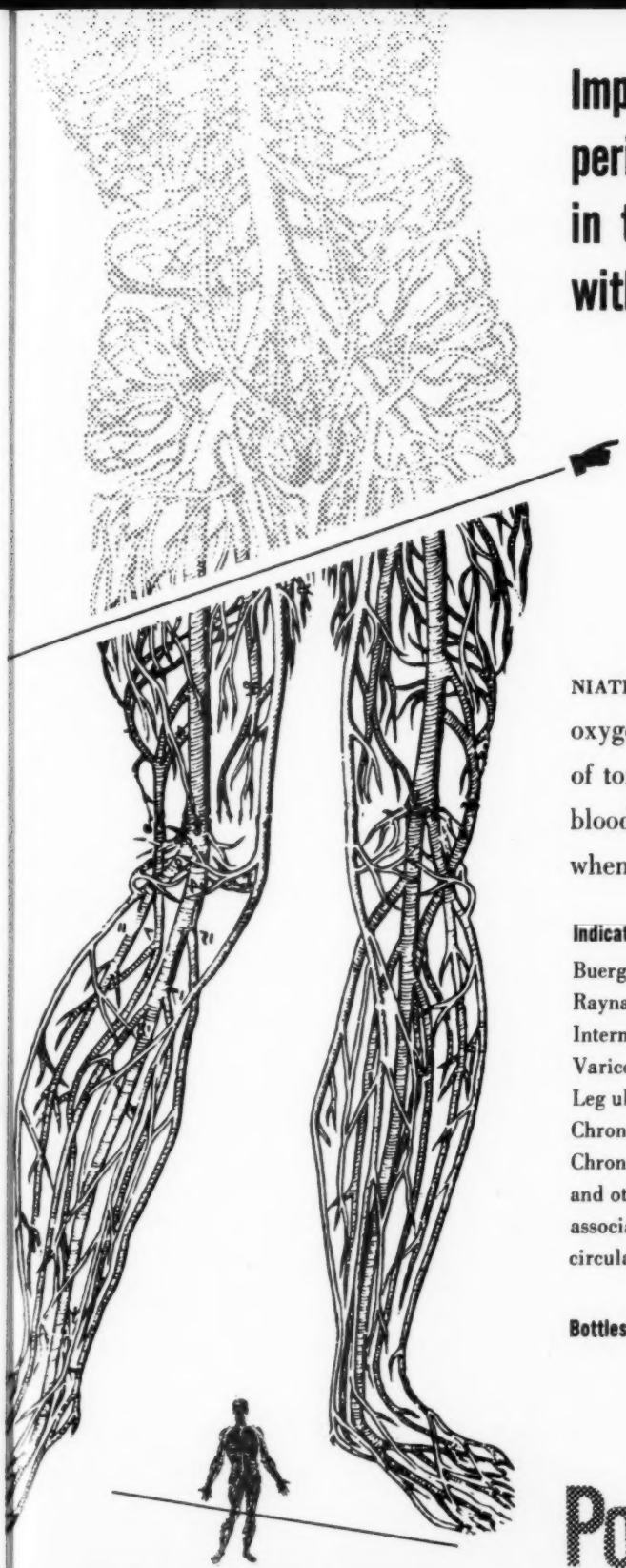

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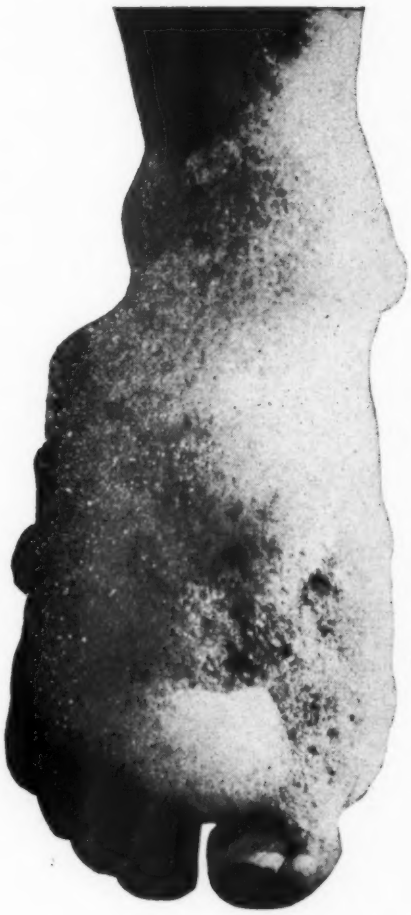

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JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

VOLUME 49 SEPTEMBER, 1959 NUMBER 9

TREATMENT OF NIGHTTIME ITCHING WITH A NEW ORAL ANTIPRURITIC: A CONTROLLED STUDY*

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Jersey City, N. J.
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Jersey City, N. J.

TREATING pruritus is often difficult because of the variety of factors that can cause it and the multiplicity of stimuli (most of which are incompletely understood) that may be involved in its production. Like pain, itching is a purely subjective sensation, varying in intensity from patient to patient and in the same patient at different times of the day. This sporadic variation is particularly common in patients with pruritic cutaneous disorders of the lower extremities. In these patients, the intensity of itching seems to follow a prescribed pattern, usually becoming more pronounced shortly before the patient retires, or when the patient is trying to fall asleep. This increased itching seems to result from the patient's coming to mental and physical rest, probably for the first time that day, or from vasomotor changes brought about by increased body temperature resulting from bed clothing.

Few of the antipruritic preparations now available consistently control both daytime and nighttime itching. Recently, a new drug, trimeprazine, a phenothiazine derivative related to chlorpromazine, was found to be an effective antipruritic when administered orally (1-7). Of the 892 patients included in these reports, at least 70 per cent and sometimes as high as 90 per cent of them obtained consistently good or excellent results after taking the drug; side effects were infrequent, and usually mild and transient.

The present controlled evaluation was undertaken to determine the effects of trimeprazine in a group of patients all of whom experienced severe itching at night associated with acute and chronic cutaneous disorders of the lower extremities.

Method and Material

Fifty-two patients (30 males and 22 females) with pruritic skin disorders (see

*An award winning paper in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1959. Presented at the Annual Meeting of the A.P.A., Waldorf-Astoria, New York, N. Y., August 1959.

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TABLE I

A Comparison of Antipruritic Results Following the Use of an Inactive Placebo and Trimeprazine

Diagnosis	Number of Patients Treated	Placebo Results E	G	F	P	Trimeprazine Results E	G	F	P
Arteriosclerosis	1			1		1			
Atopic Dermatitis	2				2	1		1	
Hyperidrosis	2		1		1	1	1		
Lichen Planus	2				2	1	1		
Neurodermatitis	1				1	1			
Pruritus Balnei	1				1	1			
Psoriasis	4		2	1	1	3	1		
Raynaud's Syndrome	1				1			1	
Scleroderma	1			1		1			
Senile Pruritus	2			2		2			
Tinea	3		3			3			
Varicose Eczema	6		2	3	1	5	1		
Varicose Ulcer	4		2		2	4			
TOTAL	30		10	8	12	24	4	2	

Statistical Results (chi-squared test) Chi-squared = 5.04 — p = .02
E—Excellent G—Good F—Fair P—Poor

Table II) localized in the lower extremities (legs, ankles or feet) were evaluated. They ranged in age from six to 78 years (average age: 42). Twenty-four of the patients had acute disorders, while twenty-eight of them had chronic ones. In general, patients with acute disorders had experienced intense nighttime itching for several days to several weeks; those with chronic disorders had experienced it for much longer periods. Patients received appropriate treatment for the underlying disorder when indicated, and were given trimeprazine for the symptomatic relief of pruritus only.

Thirty of the patients served as their own control, and were given placebos for the first three days of treatment. At the end of this time, the antipruritic results produced by the placebo were evaluated. Patients who reported less than complete relief of itching were then given trimeprazine. The remaining 22 patients included in the evaluation received trimeprazine without having first received placebo. Dosage instructions, regardless of the preparation being taken, were: One 2.5 milligram tablet before retiring, followed by a second tablet 15 to 30 minutes later if no relief was experienced. Duration of treatment varied from 3 days to three months. Urinalyses and complete blood counts were done on 15 patients before, during, and after treatment.

Results

Results were based on the degree of relief of itching, and on physical examination of the patient for signs of scratching. Results were considered "Excellent" if itching was completely relieved; "Good" if it was considerably diminished; "Fair" if it was slightly diminished; and "Poor" if it was unaffected. A comparison of the results obtained by the patients who received both placebo and trimeprazine is presented in Table I; results for the entire series are given in Table II.

As noted in Table I, none of the patients receiving the placebo reported complete relief of itching; ten (33 per cent) reported considerable relief; eight (27 per cent) reported slight relief, and 12 (40 per cent) did not benefit at all. When given trimeprazine, all the patients derived some degree of relief of itching. Twenty-four (80 per cent) of the patients reported complete relief, four (13 per cent) reported considerable relief, and two (7 per cent) reported

slight relief. The results of a statistical comparison (chi-squared test) of these data indicate that the results obtained with trimeprazine were statistically superior to those obtained with the placebo ($p = .02$). The results for all the patients indicate that 44 (84 per cent) patients received complete relief of itching, while the remaining eight (16 per cent) patients received either considerable or slight relief of itching.

In general, the response to trimeprazine was easily recognizable from that produced by the placebo. With the exception of twelve patients who required more than one 2.5 milligram tablet of trimeprazine, all the remaining patients reported that they had experienced substantial relief of itching within 15 minutes, and that complete relief was evident within 30 to 45 minutes after one dose. This was not the case when the patients were receiving placebo. Many patients who had been subject to intense itching and scratching before bed every night for months experienced adequate and, in most cases, complete relief of itching after receiving trimeprazine. Although trimeprazine was continued for longer periods in patients with chronic disorders, the initial response to therapy varied only slightly between patients with acute or chronic conditions. Due to the reduced amount of scratching observed in most patients after they had received trimeprazine, it is our impression that the total treatment time per patient was less than that for comparable patients who had not received the drug.

The most common side effect was mild drowsiness, and was reported by 28 patients. Patients welcomed this as it gave promise of a good night's sleep. Other, less desirable, side effects were: nausea (2 patients); anxiety and tenseness (1 patient); dryness of mouth (2 patients); and headache (1 patient). In all cases, these effects were mild and transient, and were never severe enough to warrant discontinuing the medication.

TABLE II

Anti-Pruritic Response to Trimeprazine in All Patients

Diagnosis	Number of Patients	Results E	G	F
Arteriosclerosis	1	1		
Atopic Dermatitis	2	1		1
Burns (chemicals)	1		1	
Burns (water)	1	1		
Contact Dermatitis (adhesive type)	1	1		
Dermatitis Medicamentosa (penicillin)	1	1		
Gout	1	1		
Hyperidrosis	5	4	1	
Insect Bites	1	1		
Lichen Planus	2	1	1	
Neurodermatitis	2	1	1	
Pruritus Balnei	1	1		
Psoriasis	4	3	1	
Raynaud's Syndrome	1			1
Scleroderma	1	1		
Senile Pruritus	2	2		
Tinea	14	14		
Unknown	1	1		
Varicose Eczema	6	5	1	
Varicose Ulcer	4	4		
TOTAL	52	44	6	2

E—Excellent G—Good F—Fair

There were no changes observed in the hemogram or in renal function as determined by the blood studies and urinalyses that were done.

Comment

In any evaluation in which the symptom being treated may result from psychogenic factors, a certain percentage of the patients respond favorably to placebo medication. Beecher (8) reports the incidence of placebo reactors in evaluations of this type as approximately 35 per cent. It is interesting to note that the incidence of placebo response in the present evaluation, 33 per cent, closely approximates that reported by the latter investigator. It should be pointed out, however, that none of these patients experienced complete relief of itching while receiving the placebo, whereas 80 per cent of them received complete relief after taking trimeprazine. Important also is the fact that 40 per cent of the patients derived no benefit while taking the placebo; while all the patients receiving trimeprazine ex-

perienced some relief of itching, even though it was only slight in seven per cent of them. Had both the preparations been equally effective (or nearly so), the results following the use of trimeprazine would have been similar, and the results of the statistical test between the differences in the proportions of degrees of relief experienced by the patients would have been insignificant. Since this was not the case, it is concluded that, in most patients, trimeprazine effectively relieves nighttime pruritus associated with many pathologic conditions.

Interesting, too, is the agreement between the proportions of excellent and good results obtained in the controlled group after they received trimeprazine (80 per cent) and proportions of these results obtained in the entire group of patients (84 per cent). It should be pointed out that the average of these proportions (82 per cent) agrees favorably with the average proportions of excellent and good results (82.1 per cent) reported by other investigators (2, 5, 6, 7) who evaluated trimeprazine. This consistency of results is impressive, and seems to indicate that trimeprazine's effect is particular, regardless of the type or the cause of the pruritus being treated.

Summary

Fifty-two patients with pruritic skin disorders localized in the lower extremities participated in the evaluation. To serve as a control group, thirty patients were given a placebo for three days. At the end of this time, those patients who had not received complete relief of itching were given trimeprazine. The remaining twenty-two patients received trimeprazine without first being given the placebo.

Results showed that none of the patients receiving placebo obtained complete relief of itching. Ten patients (33 per cent) received considerable relief, eight (27 per cent) received slight relief, and twelve (40 per cent) did not benefit at all. All the patients derived some degree of relief of itching after being given trimeprazine. Twenty-four (80 per cent) reported complete relief of itching, four (13 per cent) reported considerable relief, and two (7 per cent) reported slight relief. The results of a statistical comparison (chi-squared test) of these data indicate that the results obtained with trimeprazine were statistically superior to those obtained with the placebo ($p=.02$). It is concluded that, in most patients, trimeprazine effectively relieves nighttime pruritus associated with many pathologic conditions.

681 Bergen Ave.

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"Medicine is the only profession that labors incessantly to destroy the reason for its existence."

THE MECHANISMS CONTRIBUTING TO OSTEOPOROSIS FROM TRAUMATIC INJURY*

ROBERT R. KROUT, B.S., D.S.C.
Washington, D. C.

THE human foot, subjected to constant trauma due to the activities of locomotion, to abnormal foot-positioning, and to direct injury, may undergo circulatory and functional changes which may eventually progress to trophic changes and crippling. Osteoporosis often follows the soft tissue and bone changes. In this disease there is an abnormal porousness or rarefaction of bone through enlargement of the canals or by formation of abnormal spaces. The decalcification or demineralization is shown in an x-ray study as a decreased density of bone.

The various contributing factors to osteoporosis include disease, immobilization, vitamin C deficiency, senescence, various infections, hypercortisonism, and trauma. This discussion is primarily concerned with physiologic and pathologic alterations resulting from trauma.

The means whereby subclinical trauma becomes a causative factor in osteoporosis has been described by various authors, (1) by producing prolonged inflammatory reaction in the articular and periarticular tissues of the human foot[1]; (2) in causing traumatic arthritis,[2] and (3) in leading to pathologic changes following intra-articular fractures, dislocation, injury to the cartilages or to the soft parts. Daub's[3] suggestion that x-ray studies are of paramount importance, because they reveal the anatomic changes and, therefore, disturbed function, is not wholly true, since soft-tissue involvements, and especially energy changes, are not shown on roentgenograms. Yale[4] observes an over-emphasis upon roentgenologic interpretation, with neglect of adequate explanation of bone changes.

Histopathology

A vascular absorption from persistent vasodilatation has been noted which causes a widening of the Haversian canals, and even development of inflammatory granulation tissue in osteoporosis. The role of the osteoclasts, multi-nucleated acidophilic cells, is to exert phagocytic action upon the bones after osteolysis.[5]

The histopathologic process in bone absorption has been explained as proteolytic action initiated by osteoclasts, the organic material being removed by macrophages. Theories explaining the conditions under which the osteoclasts form and osteoporosis results are: (1) Aging or necrosis causing chemical changes which stimulate connective tissue to form osteoclasts; (2) increased pressure causing stasis in bone periosteum and bone marrow; (3) proteolytic enzyme action.[4, 6] Yale[4] believes that external pressures can cause superficial decrease in bone density.

Studies of the microscopic structure of porous bone failed to show the presence of osteoclasts, suggesting a non-cellular intervention.[7, 8] Boyd[5] suggests that the physiochemical change is that of hydrogen-ion concentration. The accumulation of carbon dioxide in an inflammation contributes to calcium dissolution. In disease, the balance between blood calcium and bone calcium is disturbed, yet in Sudeck's atrophy the general blood calcium is not altered. Normally the chemical constituents of bone matrix is 80 per cent calcium phosphate and the remainder is calcium carbonate and magnesium phosphate.

*Paper submitted in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1958. Presented at the Annual Meeting of the A.P.A., Shoreham Hotel, Washington, D. C., August 1959.

Nervous Factors

Evidence of pain, functional changes, and vasomotor disturbances (hyperemia and increased oscillations at first, and later, opposite changes), may well indicate energy misappropriation through neural pathways. The answer to this problem of pathogenesis "seems to lie in the realm of neurophysiology and, more specifically, in the field of neurovascular dynamics."[7] A balance must be maintained in the nervous system. Normal innervation is conducive to health, abnormal nerve irritation to disease. With the overstimulation of sensory nerves, functional vascular changes occur in the form of hyperemia or ischemia. Trauma to soft tissues commonly causes these abnormal reactions.

The commonest property of nerves is irritability – the capability of reacting to stimuli. Single or multiple shocks to the nerves can give rise to reactions such as pain and muscle spasms (Morton's neuralgia).

Increased oxidation occurs in the cells upon exercise, after injury, infection, and injection of foreign protein. Normal nerve impulses contribute to normal oxidation, cell charges and pH content, but "if injury or an infection causes an increase in nerve impulses, there will be hyperchanges, hyperoxidation, and too great a change in the pH content."[9] Reduced impulses reduce the electric charges in cell membranes; in absence of nerve impulses, oxidation and electric charges disappear.

Trauma to the foot can give rise to conditions producing no appreciable changes in the bones at first, as in traumatic arthritis, osteoarthritis, Sudeck's atrophy, and causalgia. To understand the mechanism by which these crippling conditions are produced, and in order to break the vicious reflex cycles, practitioners must devise new ways of restoring tissue normality with the least possible side effects.

Osteoarthritis and Traumatic Arthritis

Early writers believed that osteoarthritis has its beginning in subchondral bone, transitional bone, articular cartilage, synovial membrane, and tissue fluids.[11] Some claim that poor posture is a cause of this disease,[12] the pain causing disability arises from nerve irritability somewhere. If so, relief can be obtained by rest, correction of posture, and support of the strained part, or the relief of irritating cause. The old "wear and tear" theory tends to explain osteoarthritis in the obese patient,[11] but Heberden's nodes and subdeltoid bursitis cannot be explained by the popular theories alone.

Osteoarthritis has been induced by applying iodine or ammonium hydroxide to a joint cartilage, cauterization of the surface of joint cartilage, ligation of patellar blood vessels, joint resections, freezing knee joints, traumatic injuries induced by reflex hammers, subnormal use of joints, etc. Knock-knee experimentally induced in rabbits by manipulations, led to permanent valgus deformities of 30 degrees. The rabbits showed evidences of hypertrophic arthritis and traumatic arthritis, with osteophytes surrounding the cartilage margin, and hypertrophy of the involved bones, and hyperplasia of the synovial membranes.[11]

Traumatic arthritis is commonly followed by traumatic hydrarthrosis.[10] Several days after the injury to the knee, a serous effusion may distend the joint. A straw-colored exudate occurs, without formed bodies of blood. Leriche[10] found no assurance of success from rest, dry heat, immobilization, massage, hot poultices, or aspiration. He described three cases of traumatic arthritis without systemic infections. They resulted from traumatic injuries to the knee in one instance and to the shoulder in two others. Painful and functional disability occurred within 10 days, one week, and two weeks respec-

tively, after the injury. X-ray studies showed areas of osteoporosis of the epiphyses. Synovectomy, arthrotomy, and/or sympathectomy were performed. The synovial membranes were purplish, thickened and vascular, with villi distended by citrine. Microscopic studies revealed typical subacute synovitis and inflammation, new capillaries in the internal layer, and the superficial cartilage destroyed. Connective tissues were edematous, with many plasmocytes; lymphocytes surrounded the blood vessels; no polymorphonuclear leucocytes were present. The surrounding cellular membrane seemed to be hyperplastic. The external layer of synovial membrane was fibrous and compact; the internal portion was highly vascular.

From oscillometric tests and observations, Leriche concluded that the early reaction to irritability is hyperemia. This proved that "every traumatism, above all, is a traumatism of 'vasomotoricity'." He suggested there could be an individual susceptibility of the nervous system in relation to the type of trauma. Review of the literature has offered no explanation why all traumatic injuries do not lead to marked functional and trophic changes. Could it be that those so afflicted have additional factors of malnutrition and toxemia?

Leriche suggested treatment to prevent the usual course of traumatic hydarthrosis and traumatic arthritis as follows: Avoid message, mechanical therapy, and heat—all of which cause hyperemia. Treat with rest, cold water or ice; no poulticing, nor plaster immobilization. In treatment of synovia and osseous lesions he suggested a special type of hydrotherapy without massage, as used at Aix-les-Bains—1,200 to 1,500 liters of hot water used as hydrotherapy to the entire body. In several minutes marked changes are effected in peripheral vasomotor nerves. In serious cases, he advises surgical treatment. In three severe cases periarterial sympathectomies or lumbar ramisections were done, resulting in improved function, reduced pain, and restored calcium to porotic areas. He did not explain how abnormal reflexes contribute to osteoporosis, nor how sympathectomy brought about improvement, but he noted that his surgical procedures increased the circulation and temporarily increased osteoporosis at first.

Sudeck's Atrophy

An extremely disabling and painful vasomotor, functional and trophic disturbance may result from mild trauma or from a low grade infection, a condition variously known as acute atrophy of bone, traumatic angiospasm, traumatic vasospasm, chronic traumatic edema, peripheral acute trophoneurosis, post-traumatic dystrophy, and Sudeck's atrophy.[13] This vague syndrome, which frequently is unrecognized, especially in its milder form, Schuele[14] observed in 5 per cent of 500 cases of sprain. Sudeck's atrophy may become progressive if the mechanism is not understood, or proper therapy instituted.

The types of tissue shock causing this condition include mild trauma, massive venous trauma, massive venous thrombosis, pelvic phlebitis, nodular phlebitis, and neglected infections, sprains, dislocations, eschars following incisions, and glomus tumors.

Reported case studies,[13, 15] established the following significant symptoms: Severe pain with muscles hypertonic from increased reflex excitation, which cause malfunctioning of the part; indefinite sensory disturbances, often with hypoesthesia; the affected part extremely sensitive to draughts, temperature changes, superficial and deep pressure. Other symptoms are: Skin temperature elevated at first, later decreased; the skin glossy with bluish tint; joint capsules shrinking. After 4 to 8 weeks, the bone shows spotty atrophy which

later becomes diffuse. Growing bone may be retarded and epiphyseal lines close prematurely. Moving the contracted parts aggravates the condition. Blood flow studies show an average increase of slightly over 30 per cent, an increase which persists for many months or for several years after injury. Blood calcium and phosphorus levels remain normal, but in most cases phosphatase is slightly elevated. Histologic sections reveal the presence of edema of the subcutis, fat shrinkage, minute hemorrhages, and perivascular infiltration, nerves surrounded by a fine layer of hyperemic connective tissue, perivenous adhesions; atrophy of spongiosa and cortical bone are late effects.

Therapy depends upon the severity of the syndrome. The most conservative treatment is repeated procaine injections into the injured area. In severe cases, paravertebral sympathetic block, periarterial sympathectomy, and sympathetic ganglionectomy are used. Pain may subside rapidly after sympathectomy, but osteoporosis may persist for many months. Complete recalcification has not been observed.[16] Horn[17] in discussion of treatment of Sudeck's atrophy in the feet, suggests rest, strappings, and inlays. He regards build-ups and inlays "of great value in keeping involved areas from bearing weight." Since pressure aggravates this condition, paddings and appliances should not be allowed to press upon sensitive areas of the foot. Nonsensitive areas should be selected by palpation, then these areas padded to reduce the shock to the more sensitive areas.

The Abnormal Reflexes

Involvement of the polyarticular regions occurs most frequently in the ankle and wrist because "stimulation of the numerous articular and periarticular nerves bring about vasomotor changes that are ultimately responsible for the production of osteoporosis."[8] This suggests a nervous basis for tissue changes. Trauma may be followed by blockage in the local circulation due to vasodilatation or vasoconstriction.[10] A reflex from stimulation of sensory elements in a blood vessel may follow the pathway of afferent neurons to enter the posterior horn through the posterior root ganglion. Impulses then transmitted through the sympathetic efferent nerves leave the anterior root to join other nerves and affect the vessels.[13] This contributes to vasospasm. However, in Sudeck's atrophy vasodilatation occurs first.

In Sudeck's atrophy, either vasoconstrictor or vasodilator effects can result from continuous efferent impulses.[13] Physiologic studies show that strong stimulation at the central end of an afferent nerve causes vasoconstriction; stronger or weak stimuli to a regenerating nerve affect vasodilatation. Ham[18] claims that not all arteries have parasympathetic vasodilator fibers, but a majority of sympathetic fibers running to the blood vessels are vasodilators. The mechanism of vasodilatation is complex. The medulla has a vasoconstrictor center, controlling impulses to the arteries; afferent impulses can extend to the vasoconstrictor center and inhibit it, causing diminished tone of the smooth muscles of the vessels. Blood vessels in general are governed by the sympathetic nerves. These nerves pass through the lumbosacral plexuses and are distributed to the limb. The vasoconstrictor nerves act on the main vessels and their branches, affecting the arterioles and capillaries. Capillaries may be dilated or constricted by disturbances of the autonomic nervous system.

Surgical intervention by periarterial sympathectomy, ramisectomy, and sectioning of the posterior roots can cause temporary vasodilatation,[19] but only a temporary effect follows periarterial sympathectomy for vasoconstriction, indicating that the sympathetic fibers in the adven-

titia do not extend to distal branches of the arteries.[18]

Malfunctioning Toes

These reported findings may help to explain everyday conditions of functional foot disorders. Traumatic injury is probably the commonest cause of foot disability. Injury to the metatarsophalangeal area is readily inflicted by the pitch of a woman's heel, by overturning an ankle, and by mechanical shock to the soft tissues adjacent to the longer segments; all these contribute to distressing symptoms of the forefoot.

Since a history of trauma, though mild, may be overlooked, a doctor observing the end result may believe that from the beginning there was an "arthritic constitution," incidentally revealed by trauma. Leriche concluded that the same physiologic mechanism occurs in both traumatic arthritis and osteoarthritis. These similarly related arthritides are prevalent manifestations in the human foot. Subliminal traumata may initiate the degenerative processes. Previous to organic changes, functional changes occur through altered physiologic mechanisms.

The nerves supplying the overlying skin and muscles act upon the joint, specifically the joint capsule. The nerve bundles of the joint capsule are both sensory and vasomotor. Whereas pain sensation is in the synovial membrane and capsule, there is controversy regarding the source.[20] Although there is a localized point of pain in the arthritic joint, often it radiates in various directions. That the origin of many reflex pathways are in the joints, should be remembered in determining the nature of debilitating functional and organic foot disorders.

The four lesser toes may have in common various sensory and motor changes: abnormal sensations expressed in pain, burning or numbness; vasomotor changes manifested in coldness, heat, redness, and swelling. Involuntary muscular spasms may cause the toes to hyperextend at the metatarsophalangeal joints and flex at the interphalangeal joints. Gait and foot posture may be abnormal. After a woman has been on her feet for some time she often complains that one or more toes feel dorsally displaced and rigid, as though they are going to break off. This phenomenon occurs at rest or at night.

The same physiologic mechanism which contributes to traumatic arthritis and Sudeck's atrophy may occur in the toes to a lesser degree (without bony changes). The malfunctioning can be detrimental to ambulation and postural balance. It may be prodromal to atrophic or hypertrophic changes in the bones.

Palpation of the plantar metatarsophalangeal areas may reveal irritable sensory nerves contributing to functional (sensory, musculomotor, and circulatory) changes. The podiatrist would do well to incorporate palpation for this in his diagnostic procedure to determine if there are any local irritable points which might trigger neurovascular and neuromuscular symptoms.

Summary

1. It has been shown that traumatic injury causes nerve irritability and abnormal circulation by way of reflex arcs, leading to malfunctioning and trophic changes in soft tissues and bones.

2. Reported clinical and pathologic studies of traumatic arthritis and Sudeck's atrophy demonstrate that a nervous mechanism leads to vasomotor changes and trophic sequelae, even causing osteoporosis. Use of local procaine injections, or performing periarterial symphectomies or ganglionic ramisections, revealed that abnormal reflexes are involved.

3. An attempt has been made to show that there is a nervous basis for malfunctioning and altered circulation in the toes.

4. Radical procedures for treatment of post-traumatic injuries are discussed briefly. It is suggested that if padding is used in foot therapy for these conditions, the padding should be so placed in the nonsensitive areas, as to reduce the shock, and to assist in breaking the reflex cycles causing the pain and disability.

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SOME COMMENTS ON FACTORS AFFECTING SURGICAL JUDGMENT IN FOREFOOT PROBLEMS*

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WITH the great amount of forefoot surgery being done, it is more important than ever to discuss indications and contraindications, choice of procedure and other factors.

In my experience, the would-be candidate is usually a woman of about 50 years. In addition to the routine physical examination, there are three special factors to be taken into careful consideration.

The first is the vascular condition of the foot and leg. Very little surgery would be performed if we were to accept only the patient with the ideal vascular tree. There are many instruments which are designed to give a good index of the circulation of the extremities. The oscillometer and the calorimeter are excellent as such indicators. However, more consideration should be given to the objective and subjective findings. A foot that is cold and cyanotic is obviously a poor risk. We must first determine how far the patient can walk before claudication ensues; whether or not there has been any "breakdown" of tissue due to circulatory impairment. If there is a question of markedly inadequate blood supply, consultation with a peripheral vascular specialist should be made. In many cases

*Presented at meeting of American College of Foot Surgeons, Las Vegas, Nev., Feb. 1959.

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he may be able to improve the patient's circulation to the point where surgery may be again considered.

The irritations and infections caused by ingrown nails, heloma molle and other conditions call for an increasing blood supply. When the demand cannot be met, breakdown of tissue occurs. The patient with poor blood supply will probably be better off after corrective surgery is performed to irritated areas. Besides medication, our post-operative care includes proper shoes and balancing devices to relieve pressure areas. All of this should be designed to reduce demand on and perhaps improve the circulation.

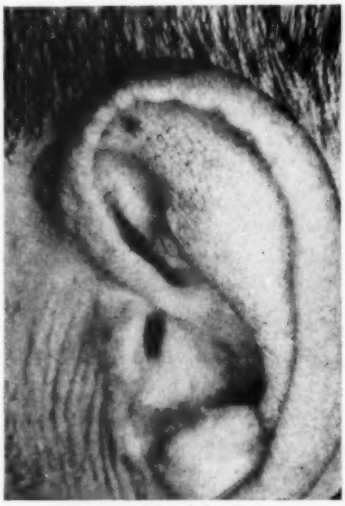

Fig. 1—Tophi of ear

The other two factors which are sometimes overlooked are stress and gout. The stress factor can be greatly reduced by first determining whether or not the patient has the ability to withstand surgical shock. Adrenal cortex failure can occur in a patient who has a past history of corticosteroid medication. A resultant atrophy may lead to a deficit of the necessary substances needed to combat surgical shock. Additional amounts of cortisone or cortisone-like products must be given the patient before surgery, at the time of surgery, and post-operatively, in consultation with the patient's physician.

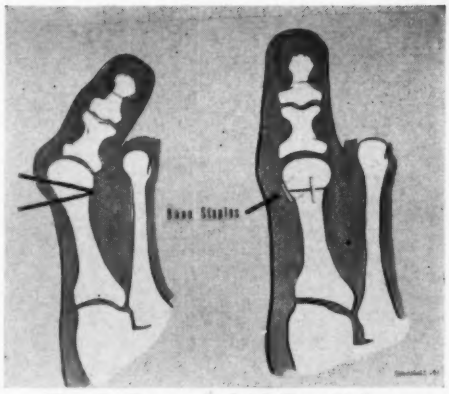

Fig. 2—Congenital Hallux Valgus

The third factor which should be given much thought and consideration is the disturbance of uric acid metabolism in the patient. Latent gout may be difficult to diagnose. Laboratory methods are not always reliable in the evaluation of gout. Comroe[1] states that the only pathognomonic sign of gout is tophi. The most common location of tophi is in the upper border of the ear, (Fig. 1). In many cases, trauma, especially surgical trauma, will cause an ankylosis of the joint in a patient with gout. It is very disappointing to all concerned when the end-result of hallux valgus surgery is a painful, stiff joint. In some cases, the surgical trauma may cause a general flare-up of gouty arthritis. In the suspected gouty patient, the administration of Colchicine or Benemid®[1], five days prior to surgery and for several weeks post-operatively, will insure a more successful result.

Procedures of Choice

Hallux valgus is a common foot deformity met by the podiatrist and many procedures are advocated for this condition. Among the most frequently used are the Keller, McBride and Silver operations. The medico-legal acceptance of a surgical procedure is that which is standard and per-

®[1]Merck, Sharp & Dohme ®[2]Bauer & Black

formed by the average specialist in the community. Most textbooks on orthopedic surgery give the Keller, McBride, and Silver procedures the most prominence. However, there are others that accomplish the same result when done by the experienced surgeon.

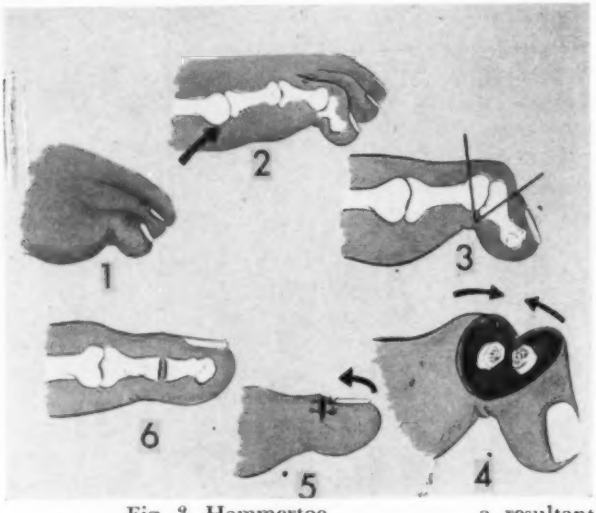

Fig. 3—Hammertoe

There are, of course, exceptions. One of these exceptions applies to the congenital hallux valgus (Fig. 2). In this condition, the articular surface of the head of the first metatarsal is directed in a valgus direction, and a bunionectomy for this condition is not indicated. The proper procedure would be a wedge resection osteotomy, bringing the articulating surface into proper alignment.

The Keller operation is indicated where there is a long first toe and where hallux rigidus is present. This is not a difficult operation. However, there are two points of caution:

1. Extreme care should be taken not to injure or sever the extensor or flexor tendon.
2. A common error is the failure in not removing enough bone from the proximal phalanx. At least one-half must be taken out.

It must be remembered that in doing this operation the short muscles which attach to the base of the proximal phalanx are no longer functional and, therefore, a slightly unstable foot results.

Hallux valgus with a mild-to-moderate degree of metatarsus primus varus is best corrected by the McBride method. The excision of the fibular hallux sesamoid must not be omitted.

The attempt to compress the forefoot transversely to approximate the first and second metatarsals is accomplished by means of a heavy chromic catgut suture placed circumferentially around the necks of the first and second metatarsals. Many times however, in the attempt, the base of the first metatarsal is pulled out, thus causing a subluxation of this joint with a resultant traumatic arthritis. I do not recommend the tying of the metatarsals together.

For the simple hallux valgus with bunion formation, the Silver procedure fits the situation very well. The deformity in this condition is on the borders of the first metatarsal and usually is accompanied by a thickened bursa. A "U" flap is made in the capsule over the metatarsal head only. The offending portion of bone is trimmed off by an osteotome and the capsule and subcutaneous structures closed by 00 chromic with the knots buried. Skin closed by 000 Dermal sutures.

Metatarsus Primus Varus

The deformity of metatarsus primus varus is so great that it is practically impossible for the sufferer to be fitted in a shoe. About the only type of foot gear that can be worn is the so-called "molded" shoe. The correction of this condition is by surgery. Lapidus[2] advises a wedge osteotomy of the base of the first metatarsal

and cuneiform, also an arthrodesis at the base of the first metatarsal to the second metatarsal. Billig[3] recommends a wedge osteotomy, utilizing the principles of telescoping and impaction. An important consideration of these operations is to keep a true plantar angulation of the first metatarsal.

Consideration of the Four Lesser Toes

Hammer toes, excluding the arthritides, congenital problems, and neurological conditions, are usually caused by one or more toes projecting more distally than is normal. Continuous wearing of shoes designed and manufactured for average feet causes a buckling of the affected toes and hence permanent changes take place in the joints. A particularly painful toe deformity is one in which the distal phalanx is sharply plantar-flexed. The lesion of the end of the toe is caused by constant irritation, the toe striking the sole of the shoe with each step. The only effective measure is surgery. The result is a shorter straight toe, as it should have been in the first place (Fig. 3). Opposing elliptical transverse incisions are made dorsally over the middle and distal joints; a quarter-inch section of skin and an eighth-inch section of bone (together with the cartilage) is removed from both sides of the underlying joint. The distal phalanx is then dorsally positioned to bring the edges of the wound into approximation. It may be necessary to widen the incision to get a more perfect alignment. This method is very useful in correcting varus, valgus, and dorsal or plantar deformities of the phalanges. The amount of correction will be in proportion to the amount of tissue removed, and this may be done from a plantar, dorsal, medial or lateral approach (Fig. 4).

The average chronic heloma durum of the fifth toe is best treated surgically, through a longitudinal incision[4]. Fowler[5] recommends a partial proximal phalangectomy and, if necessary, a portion of the lateral border of the middle and distal phalanx is removed (Fig. 5).

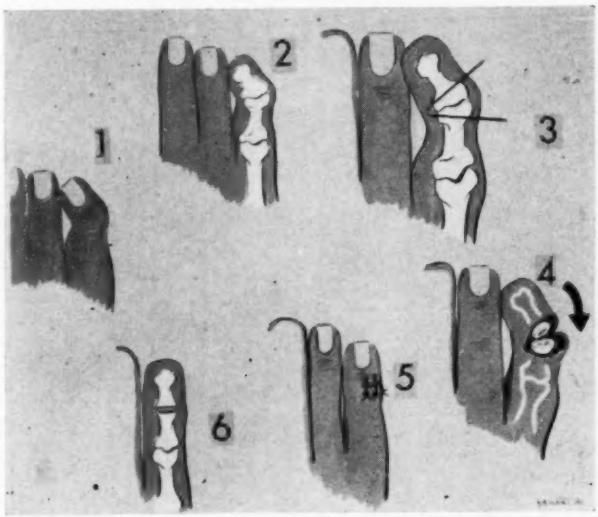

Fig. 4—Varus Hammertoe

Austin[11] recommends a middle phalangectomy where the deformity is caused by a shortening of the flexor digitorum brevis muscle.

McCain[12] suggests a transplant of the flexor brevis tendons for correction of a dorsally extended proximal phalanx.

The scars left by incisions of the dorsal surface of the four lesser toes disappear very rapidly. In a few months there is very little evidence that the skin had been incised.

Neuromas and Keratoma-Like Problems

An extremely painful condition of the forefoot is many times caused by a tumor of the most lateral branch of the medial plantar nerve. The site is usually between or slightly anterior to the heads of the third and fourth metatarsals. This condition is

often refractory to conservative treatment and, as soon as a diagnosis is made, surgery is recommended[6].

Sullivan[7] has made an observation that in suspected cases of neuroma, there will be an abnormal separation of the toes, distal to the affected area. (I would like to have information from others who have observed this phenomenon.)

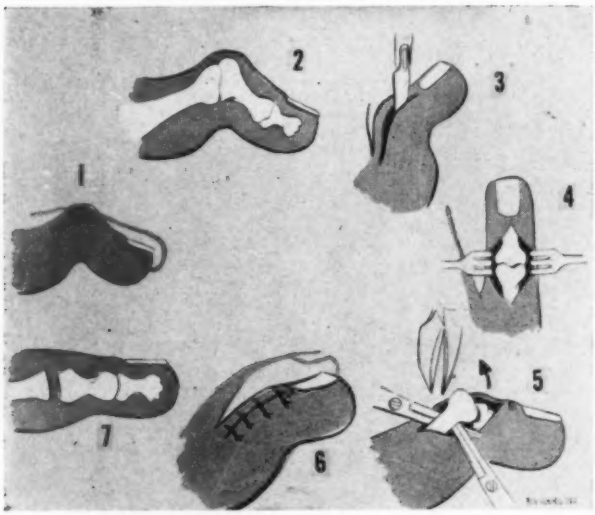

Fig. 5—Heloma Durum

To differentiate between peripheral nerve pain and neuroma, one should test for fascial tightness[8, 9]. If the test should cause an exacerbation of the complaint, surgery is not indicated. Many needless surgeries would be avoided if the above tests were done. Lesions of the plantar surface such as intractable verrucae and keratoma are best treated by surgery directed to the metatarsal head[10]. It has been my experience that in sixty per cent of the cases, beneficial results are obtained by resection of the plantar condyles of the heads of the metatarsals. The most effective method is head resection of the four lesser metatarsals for plantar lesions, even at the expense of shortened toes.

Sutures

Perfect approximation is most important for good wound healing. Suture material should be chosen for its indicated use. Absorbable sutures are used for deep closures (with few exceptions). In suturing deep wounds it is necessary to close by layers and to "bury" the tied ends. This is accomplished by directing the suture from deep to superficial, crossing over and going in on the same plane, superficial to deep, and tying the ends. In this manner the knots are buried. I believe that considerably more time should be allocated to wound closure. This would insure healing by primary intention and a much more successful end-result.

Post-Operative Re-Dressing

In an effort to give the patient maximum care, many physicians and podiatrists will re-dress the incision 24 to 48 hours post-operatively. Not only is this practice unnecessary but it may even lead to contamination of an absolutely clean and sterile area. Whenever possible, we should try not to disturb the Telfa®[2] dressing until sutures are removed in about 7 to 12 days. Care must be taken so that the ends of the toes may be visible and available for palpation to ascertain possible circulatory impairment.

Post-Operative Swelling

Post-operative swelling concerns the foot surgeon very much. The swelling produces pain and prolongs disability. Arterial and venous bleeding are effectively controlled by mechanical means. Much of foot surgery involves cutting of bone—therefore our concern is with capillary oozing.

In these cases the problem of oozing is certainly an important one to the surgeon. However, from the viewpoint of the patient, the subjective manifestations of the problem frequently assume a role far out

of proportion to the actual clinical significance. The degree of pain and the length of disability all too often serve as the patient's major criteria of the operation's "success."

The problem of post-operative swelling, lesion oozing, and bone oozing, is best handled by proper pre-surgical preparation of the patient. If this is done, operative and post-operative oozing problems are mild or nonexistent. Proper pre-surgical preparation includes insurance of normal capillary integrity and the correction of capillary fragility—a common abnormality, especially in the older patients.

In a controlled series over a period of 3½ years I have been using, in order to reduce post-operative swelling and to reduce incidence of capillary oozing, a combination of two vitamin P factors, e.g. hesperidin methyl chalcone and esculin with ascorbic acid plus vitamin K in injectable form. This specific combination[13] shows significant ability to refurbish intercellular cement at the capillary level. Simultaneously, it would appear that vitamin K synergistically enhanced by the C complex (ascorbic acid plus P factors) tends to normalize prothrombin levels and acts as a biological hemostat. Given in adequate doses the preparation measurably reduces the incidence of edema, hematuria, and ecchymosis, meanwhile enhancing wound healing and tissue repair.

The product which until recently has been available in 10 cc. lyophilized vials and needed reconstitution with saline or sterile water is now being made available in a more practicable form, i.e., a 5 cc. injectable ampule which contains the same quantity of ingredients as the 10 cc. lyophilized vial did.

I have found the most satisfactory routine regimen to be: Oral therapy, i.e., 2 tablets twice a day several days before the surgery, 1 ampule intravenously or deep gluteally if intramuscular injection appears more appropriate, 12 to 24 hours pre-operatively. This dose is followed by another ampule just prior to or during surgery. Occasionally persistent oozing in the post-operative stage occurs, which is usually controlled by one or more injections, without complications.

Summary

Some comments have been made on pre-operative precautions regarding vascular status, stress and gout. Procedures of choice for various forefoot surgeries have been discussed. Some comments have been made also in sutures, redressing and post-operative swelling. It is the hope that these comments will enhance the operator's surgical judgment.

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ULTRASONIC THERAPY AS APPLIED TO THE FOOT*

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BECAUSE Ultrasound is a new and different therapeutic energy, variations in opinion relative to its biologic effects are to be expected. However, there is no justification for an "alarm reaction" or the brand "danger" to be tacked on this modality. If a practitioner has an understanding of "sound" and uses the energy within its scope, limitations, indications, and contraindications, he thereby removes the "danger" label on this therapy.

Psychophysically, sound is a sensation due to stimulation of the auditory nerves and auditory centers of the brain, usually by vibrations transmitted in a material medium, commonly air, affecting the organ of hearing.

Physically, it is a vibrational energy which occasions such a sensation. Sound is propagated by progressive longitudinal vibratory disturbances (sound waves). The sound waves will pass through or be conducted by elastic materials such as air, water, metals, earth, rock, etc. The moving waves are purely physical or mechanical in nature, in that each complete wave includes an area of compression and a corresponding area of rarefaction.

When a pebble is dropped in a pond of water, rippling tiny waves begin to travel outward. The body of water as a whole does not move, yet the waves continue to travel. A closer examination of these phenomena will reveal that the crest of each wave is higher than normal standing water level, while the valley between the waves is correspondingly lower than the normal water level. These crests and valleys represent the areas of compression and rarefaction which occur as sound waves travel through any material.

Thus, it may be understood that sound waves, in passing through any material, create a series of alternate areas of pressure and rarefaction, in which particle motion is extremely slight (minimal), yet the speed of acceleration is high.

Variations of vibrations in sound waves depend upon the following:

1. The frequency—referring to the number of times the waves occur each second.

2. Amplitude—a measure of the force or power existing in the wave and is represented by the degree of compression and rarefaction. Amplitude, therefore, is a direct result of the force applied causing the wave.

Frequency of a sound, therefore, is determined solely by the vibrating rate of the force which produces the wave.

The next prefix "ultra," means beyond due limit (of audibility in this case, extreme). Ultrasound is defined as the sound or vibratory waves produced beyond the range of audibility or hearing perception; just as ultra-violet is a light energy produced which is beyond or outside of the visible spectrum at its violet end; also the same as infra-red or ultra-red being those rays lying beyond the red end of the visible spectrum.

Ultrasonic therapy is the application of sound waves that are beyond the normal limit of audibility (exceedingly high frequency) to human tissues for the purpose of ameliorating pain; destruction (it is at times used as a surgical instrument) and as a diagnostic instrument.

We as foot specialists are particularly concerned with the following: Contraindications as to use: (1) Closed infected areas with abscess being present, (2) Children or any case with incomplete ossification of epiphyseal junctions, (3) Pregnancies, (4)

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†Presented at Region Three meeting, Atlantic City, N. J., May 1959.

Malignancy or areas of suspected malignancy, (5) The orbit of the eye, (6) Over the heart.

Principles and Effects of Ultrasound

Vibrations above 20,000 oscillations per second are not audible to the human ear and are called ultrasonic. For therapeutic use, frequencies of between 800 and 1,000 KHz (kilo Hertz—in Europe a cycle is called a Hertz and 1,000 KHz is a frequency of one million oscillations per second) are most suitable.

An ultrasound unit consists of two principal parts: a high frequency generator and a transmitter. Ultrasound is produced by utilizing the piezo-electric principle of Curie described in 1880. A quartz plate which is sufficiently elastic to oscillate is excited in a high frequency electric field. Since the transmission of sound depends upon the density of the medium transversed, and inasmuch as quartz is 1,000 times denser than air, there is virtually no transfer of ultrasound from the quartz disc through the air. Ultrasound waves require a conducting medium. They differ from sound waves in that they can be concentrated into a beam and directed toward a particular object, like a light ray. In an ultrasonic unit, the energy generated travels through a flexible cable to the treating or sound head called transducer and is a flat metal surface. No other part of the unit emits sonic energy.

Among the biological effects of ultrasound are heat generation and the important phenomenon of cavitation—a process in which elastic molecular connections are ruptured and gases liberated. Changes of the chemical state may take place as flocculation in colloidal substances, oxidation, polymerization and coalescence. High ultrasonic intensities may cause cellular destruction. Limited ultrasonic intensities produce beneficial stimulation of the metabolism of tissues.

In this range the chief biological manifestations are:

a. Micromassage, produced by the mere passage of high frequency waves.
b. Deep heat generation, produced by the "reflection-back" or "echo" of the high frequency waves traveling through the various densities of fatty tissue, muscle fibre, connective tissue skin, bone, etc., in the body. Each part having its own "speed conduction" of sound. The heat energy is deposited locally in the path of the sound beam (sonation) and the distribution if fairly even in all tissues that the beam penetrates. This heat production results in a dilatation of the blood vessels and increased blood supply to the area being treated.
c. Nerve sedation, produced as a by-product of the heat generated.

The basic rationale in using ultrasonic sonation is the re-establishment of normal vascularity and the sedation of nerves by the production of deep heat by the micro-mechanical-thermal reaction of human tissues to ultrasonic energies.

Positions and Procedures for Use of Ultrasonic Therapy

(1) Remove all hair. (2) Remove all air. (3) Ultrasonic conductions demand perfect coupling.

Static or fixed positions—use very low intensities (.1 to .5 w/cm2).

Mobile circular action—on overlying skin with mineral oil; with part immersed under water, head ½" to 2" away.

Stroking action—either bring to or draining from a part. Unit to be turned down at each opposing stroke.

Note: Where the contour will lend itself, the direct method of application is preferable. Otherwise, use under water method with a deep enough pan of water. Allow for displacement of part being treated, hand, transducer head and motion. Keep one eye on the meter and the part treated,

and one on the patient and his response to treatment.

General Considerations

(1) It is inadvisable to delegate the application of ultrasound to other than trained hands.

(2) It is better to undertreat than overtreat. There is no minimal wattage—maximum is patient tolerance. Using low intensities for a longer period is generally better than using high intensities for a short period. This requires good judgment of patient tolerance.

(3) It is good procedure to give each patient a complete x-ray examination and neurological examination of both feet. Otherwise they are not candidates for the application of ultrasound. It should be assumed that contraindicated pathology is present unless proven otherwise. Use the same strict concepts that apply to a surgical case.

(4) Only assure the patient that the modality is being applied in an effort to help him. Stress the importance of accumulative effect. Adhere to a planned treatment schedule even if patient has no pain after the first application.

(5) An acute condition may require 2-3 treatments weekly for one or two weeks. A chronic condition may require 1-2 treatments weekly for 6-8 weeks.

(6) Anticipate an occasional "flare-up" of pain after the first treatment. If it happens again, re-examine your patient, re-evaluate your case.

A New Use for Ultrasound

Physicists in this country by 1953 had mathematically formulated a property of ultrasound which has been termed "flow effect." Aldes, a pioneer in ultrasonic therapy, Cedars of Lebanon Hospital, Los Angeles, California, has conducted experiments to show the presence of flow effect. From his findings, he accounted for ultrasound's decongestive abilities and from this, deduced that ultrasonic's flow effect had excellent drug dispersing properties if applied immediately after a drug injection. His paper, "Has Ultrasound Proved Successful in Clinical Medicine?", reports using hydrocortisone as the drug dispersed by ultrasound with excellent results. To his, I add my experience in using this technique. For me this has proven remarkably more successful and speedier in patient recovery in joint inflammation and pain, as compared to the use of ultrasound alone or hydrocortisone alone.

Others have expanded the basic dispersal concept and are using ultrasound for many types of injections. For instance, if ultrasound is used to disperse an anesthetic material, the resulting anesthesia is more complete, faster in action, and has a prolonged effect. Another very important factor is that ultrasound treatment eliminates soreness and hematoma, sometimes caused by the needle puncture. This adds a medical aspect to ultrasound. When using ultrasound for its "flow effect" with injectables, it should be applied only two minutes at a low voltage (.5-1.0 w/cm2) so as not to cause dilution of the drug by dissemination through too rapid absorption of the injected drug.

Some possibilities for investigation are:

(1) Fungicides, better penetration into tissues—nail or epidermis—with the "flow effect" of ultrasonics.

(2) Muscle spasms, anesthesia of innervation point followed by ultrasonic therapy.

(3) Capillary vasodilators applied topically and "flowed" into tissues with ultrasonics.

1436 South Broad St.

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

THE TREATMENT OF REFRACTORY FUNGUS INFECTIONS WITH FUNGACETIN (TRIACETIN)

MARTIN E. KARNS, D.S.C.*
Miami Beach, Fla.
ROBERT PARKER, D.S.C.*
Ft. Belvoir, Virginia

REFRACTORY dermatophytoses offer a severe test of the efficacy of any new fungicide, which must remain effective and safe over long-term use. After prolonged, continuous prophylactic application of many preparations, patients often develop tolerance with spread of the infection or untoward reactions in other areas of the body.

This report describes the prolonged use of an ointment form of Fungacetin®[1] in podiatric patients with tinea pedis infections.

Method

Twenty-five patients, 19 men and 6 women ranging in age from 18 to 88 years, were selected for this evaluation of Fungacetin ointment. Two patients had E. floccosum infections and the remainder, T. rubrum infections. Except for ten patients with acute or subacute infections (lasting for one month or less), all these cases of tinea pedis had persisted for up to 13 years and had proved resistant or only minimally responsive to previous therapy with undecylenic acids.

Fungacetin ointment was applied twice daily for two to six weeks (average: three and one-half weeks). In four patients with especially severe acute infections, potassium permanganate soaks were used concomitantly; no other concomitant therapy was used.

Results

Results of therapy were judged according to the following criteria: the response was called *excellent* when there was complete disappearance within one week of such signs of infection as scaling, vesiculation, maceration, and eczema and of symptoms of itching, pain, and burning, with no recurrence when therapy was discontinued. Results were called *good* when signs and symptoms disappeared completely but the response was delayed. Results were called *fair* when improvement was temporary and *poor* when there was little or no change in intensity of signs and symptoms.

According to these criteria, Fungacetin ointment produced excellent results in six of the chronic patients, good results in five, fair results in two, and poor results in two. Of three patients with subacute infections, two obtained excellent results and one, fair results. Four patients with acute infections obtained excellent results; two, good results; and one, fair results. Of all the 25 patients, 48 per cent obtained excellent results; 28 per cent, good results; 16 per cent, fair results; and 8 per cent, poor results. Significant benefit (excellent or good results) was seen in 76 per cent of the patients treated with Fungacetin ointment. Five of the patients who obtained excellent or good results had proved resistant to therapy with other fungicides.

Almost all the patients who benefited from therapy reported relief from symptoms of itching, pain, and burning shortly

* From the Podiatry Clinic, DeWitt Army Hospital. Karns is now in private practice in Miami Beach, Florida.
®[1] The G. F. Harvey Company, Inc., New York.

after the beginning of therapy, and marked clinical improvement was generally apparent by the end of the first week of therapy. Even the patients with chronic infections who obtained good results (partial but lasting improvement) commented that their infections were better controlled than under any previous therapy. Moreover, there have been no recurrences of infection in patients who were treated successfully, even in those whose infections had persisted for prolonged periods.

Summary

Fungacetin ointment was used to treat 25 patients with acute, subacute, or chronic tinea pedis. Used twice daily for two to six weeks, the preparation produced rapid or delayed healing in 76 per cent of the patients, several of whom had been resistant to treatment with other fungicides. Although this survey is limited, the results indicate that Fungacetin is a potent fungicidal agent that is appropriate for prolonged treatment of acute, subacute, and chronic dermatophytoses.

311 Lincoln Rd.
DeWitt Army Hospital

ATYPICAL GOUT—A Case Report

HERMAN G. MILLER, D.S.C.*
Chicago, Ill.

Miss L. P., 22, presented herself for consultation with the following history: Intermittent pain on the dorsomedial aspect of the shaft of the first metatarsal, left foot, of about one year's duration. Some pain, though minimal, was present constantly, but during the acute state it remained for 3 or 4 days and was severe. The pain began with walking, but sometimes not until mid-afternoon.

The patient was obese and anxious, though cooperative. Further history brought out that the first pain began after a party, but there was no history of trauma, nor could the patient recall any incident that may have precipitated the attack. There was no apparent nocturnal discomfort as sleep was undisturbed. Appetite was very good with no recent changes in daily habits. Her diet was high in carbohydrates, and especially "eats, drinks lots of chocolates, Pepsi-Cola and coffee."

Examination revealed that the shoes were moccasin type, very tight over the vamp, having been stretched by the foot. Palpation localized the pain to the dorsomedial aspect of the head of the first metatarsal. Slight pressure brought marked response from the patient. Vascular, neurologic and orthopedic examinations were negative. There was no visible edema or erythema, and there was no history of edema, erythema or ecchymosis. In view of the pressure of the vamp of the shoe directly over this area, a working diagnosis of periarticular fibrositis was made, with reservations of possible arthritis, capsulitis, bursitis, periostitis or gout.

The patient was given therapy with ultrasound, instructions for the purchase of a basic shoe that would offer no pressure on the involved area and a prescription for Pabalate®[1] tablets.

On the return visit the patient advised she felt better, and was wearing shoes as recommended. Ultrasound therapy was again given. Improvement continued into the third visit with the above therapy. On the fourth visit the patient advised the pain had returned, beginning while at rest without shoes in the evening and was acute. Patient complained now of some paresthesia in the left leg, extending to the knee. Radiographs were taken and the patient referred for blood uric acid. The x-rays showed small punched out areas on the medial side of the head of the first metatarsal. No other pathology was

* Chicago College of Chiropody

® [1] Robins

noted, and the x-ray of the right foot was negative.

That evening the patient telephoned the office and advised that the foot was extremely painful and begged for "something" to ease the pain. The "pills" no longer helped. Colchicine®[2] 0.5 mg. every hour continuously until relief or gastric disturbance occurred was prescribed. Paregoric was also recommended to have on hand. The patient returned to the office three days later.

The blood uric acid was 4.65 mgs., but the patient advised complete cessation of pain following the use of the Colchicine. A low purine diet was recommended and instructions for further care were given. On the patient's return one week later, she advised me she had had no pain since the previous visit.

On the basis of history, x-ray and response to Colchicine, the diagnosis of gout was entered. The patient, to date, has not advised of further distress.

1422 W. Monroe St.

®[2] Abbott

CONSERVATIVE TREATMENT OF VERRUCA PLANTARIS FOR CHILDREN

WALTER W. OLIVER, D.S.C.
Chicago, Ill.

NEVER has a single foot ailment produced more methods of treatment than the common juvenile and occasionally adult single or multiple verrucca plantaris. We continually read of experiences using one method or another in publications or advertising literature and the podiatrist has to choose from among them with care in individual adaptation to each case.

The majority of patients who present themselves with this condition range in age from 6-14 years and are by nature fearful and apprehensive about treatment. Usually the parents have already used "corn medicine" or other medication from the neighborhood drug store to no avail and this apparent stubbornness of the lesions to yield to home treatment creates a psychological state which calls for extreme patience on the part of the podiatrist. Since the method here described seldom requires more than 4-8 office visits 3-4 days apart, as is usual with other types of treatment, is almost completely painless, requires no dressings and is ambulatory, it is the best choice, in my opinion, for these children who can and do keep their appointments without requiring parent attendance. This office has used this system with complete success in a large number of cases for the past 10 years.

The treatment consists of ordinary callus debridement without hemorrhage and the application of bichloracetic acid®[1] followed by cryotherapy.®[2]

The treatment for the first 2 visits consists of callous debridement without hemorrhage and 2 or 3 applications of bichloracetic acid. If this is done carefully, there is no discomfort and the confidence of the patient is won. The use of water is interdicted the same day. The neoplasms now stand out in bold relief.

On the third visit, cryotherapy is applied with pressure to all the larger growths. Treat the growths which fit one of the applicator sizes first and then treat the ones that are smaller than the applicator size by shielding them with a small piece of moleskin having a small hole cut in it the exact size of the lesion. It is not necessary to treat the petechial lesions in the disseminated types of cases with cryotherapy. Acid application alone will suffice for these.

The patient is told honestly what to expect from cryotherapy, that at first the "ice" will feel cold, then warm, then hot. He is asked to tolerate the heat as long as he can plus the count of ten which he

®[1] Kahlenberg laboratories
®[2] Kidde dry ice apparatus

does himself. Usually the child is proud of his bravery and should be rewarded with some trinket or inexpensive gift. (Boys like the used CO_2 cartridge to use as "bombs.") 30-70 seconds of contact is sufficient to thrombose some of the deeper vascular structures and enhances the penetration of the acid. It is well to inform the child that if burning should occur after one of the treatments, it is not dangerous, but rather a good sign, and to remove his shoe and cool his foot. When it occurs, it does not last over a half hour. Formation of a mild abscess or granular disintegration which should be cleaned out and sterilized signifies completion of treatment. No scars result from this treatment. Recurrence of incompletely destroyed growths is rare and can be detected 2 weeks after completion of treatment.

The satisfaction of children with this method of treatment has been demonstrated many times through parents and relatives.

5538 W. Chicago Ave.

INCLUSION CYST OF THE RIGHT HEEL

A Case Report

ALLAN H. TOUB, D.S.C.*
Madison, N. J.

An inclusion cyst is the name given to a cyst in the connective tissues which generally infolds a portion of epithelium. Actually it can be considered an adventitious cyst, one which surrounds a foreign body or secretory material. It is possible that this type of cyst originated from a sweat gland. Review of the literature indicates that a lesion of this kind occurs in the foot very infrequently, classifying it as a rare growth of this region.

On February 6, 1959 a 33-year-old white female presented herself for examination of her right heel with a large inflamed swelling over the attachment of the tendo Achillis. The patient had difficulty wearing shoes and the constant irritation caused her to seek relief. Palpation showed the skin to be freely movable over the lesion, but the lesion itself appeared to be firmly attached to the deeper tissues. The lesion had been present for approximately one year. X-ray examination revealed an opaque area in the region of the right calcaneous which was circumscribed and sharply demarcated from the rest of the area. The lesion was located between the skin and tendo Achillis. No bony overgrowth was seen and no calcification was noted. The tentative diagnosis was a posterior achillobursitis and surgical excision was advised.

On March 11, 1959 the patient presented herself for surgery. The pre-operative laboratory tests were not significant.

The patient was given a capsule of Seconal Sodium®[1] gr. iss one half hour before the operation. The patient was placed on her abdomen so that the operative area would be easily accessible and the skin cleansed with benzene and then pHisohex®[2] and Tincture of Merthiolate®[3]. Since the circulation was normal, a Martin bandage was used to provide a bloodless field of operation. Anesthesia was 6 cc. of 2% Xylocaine Hydrochloride®[4]. Care was taken not to puncture the lesion with the needle.

When anesthesia was complete, a 2″ incision was made lateral to the growth and tendo Achillis starting superiorly and curving downward, ending just slightly below the lesion. The skin was then retracted with Allis clamps and blunt dissection used to separate the underlying connective tissue from the growth. Though the tissue was easily separated,

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® [1] Eli Lilly & Company. ® [2] Winthrop. ® [3] Eli Lilly & Company ® [4] Astra.

the growth was found to be firmly adherent to the sheath of the tendo Achillis. Very careful sharp dissection was made in order to excise the lesion but not to incise the tendon. During this procedure the lesion ruptured, spilling a very white fluid into the area which was aspirated. The lesion was then removed without cutting the tendo Achillis and the incision checked for any remnants which were not found. The wound was closed with 7 000 nylon sutures (interrupted), and a pressure dressing of Telfa®[5] and sterile gauze was applied. The patient was then given a prescription for Demerol 100 mgm. with directions to take one every hour for 4-6 hours and complete bed rest.

Two days later the wound was dressed. There was no infection present and no discoloration was evident. There had been post-operative pain. Sutures were removed at 13 post-operative days. A butterfly dressing was applied to prevent any possibility of slight gapping of the incision. Since there was some strain in the region of the plantar fascia due to the abnormal walking on the forepart of the foot for several days, the foot was strapped with a Campbell's rest strap which afforded relief. At 21 days the area was completely healed.

The pathologist's report was:

> "Microscopic section reveals a fibrous wall with cystic lining and chronic round cell infiltration. The tissue is completely benign and should not recur."

Diagnosis: Inclusion cyst, right heel.

26 Main Street

®[5] Curity.
®[6] Winthrop-Stearns.

Reference

1. Department of Pathology, Riverside Hospital, Boonton, N. J., Personal Communication, April 1959.

"Sweep your hearts and clense those roomes. Doe not leave the dust behind the doore, for that is a sluts tricke: doe not remove sin out of the tongue, and out of thy eye, and out of thy hand, and leave it in thy heart."

Thomas Hooker

JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

PUBLISHED UNDER THE DIRECTION OF THE BOARD OF TRUSTEES BY THE
AMERICAN PODIATRY ASSOCIATION

3301 Sixteenth Street, N.W., Washington 10, D. C.

A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S INAUGURAL ADDRESS

"I BELIEVE"

Just twenty years ago Medicine acknowledged that we satisfied a gap in the public health that they had failed to fill. This statement may be adequate to some. However, to the leaders that you have chosen to represent you and to guide the destiny of your national organization, it is important to analyze the statement carefully. Has the gap been filled? Have we as a profession accepted this responsibility to its fullest? What have we done since this statement was made? What are we doing now? What must be done in the immediate future to secure our rightful place on the medical team, remembering our main goal, "The best possible foot health care to every American"?

In answer to the first question, "Has the gap been filled?"—there are differences of opinion. I believe that the gap has not been completely filled. I believe that we have made a good beginning, but only a beginning, and the future of this mission lies in the dedication of all of us, to this goal.

In answer to the question, "Have we as a Profession accepted this responsibility?"—Here again, each of us must search our souls for the answer: for it is the combined efforts of all of us that will be heard.

I believe that it is important that we now review what we have done and are doing since the opening statement was made, and what we should do.

1. *Improve and broaden our educational requirements.* No other accepted, responsible profession in history has, in the short life of its formative stages, raised its standards so quickly. However, we must continue to broaden our educational program, not necessarily in years, but in quality. The time has come, if we are to be called upon as the responsible members of the medical team, for the nation's foot health, to make available the finest and fullest medical backgrounds. Unless we wish to be relegated to the category of "technician," improved basic medical sciences, second to none, are mandatory, plus a broadened clinical program. When this is accomplished, both student and practitioner may, if interested, qualify themselves for any of the specialties that are needed within the field.

MARVIN W. SHAPIRO

Toledo, Ohio

Assumes Office of President
AMERICAN PODIATRY ASSOCIATION
(National Association of Chiropodists)

2. *Our journal, annual meetings, as a potent force for post graduate education.* Few people within or outside the profession would debate the dramatic change in our JOURNAL. Its maturity has been as rapid as any in the medical field. A careful study of its contents will reveal the quality of the material and the opportunity it offers its readers for further education. Each month more medical leaders, science writers, and major and allied medical organizations are receiving the JOURNAL, studying its contents, and referring to it as an authoritative manual. It has been of some stimulating value to affiliated societies to begin or enlarge their own periodicals.

Our annual meetings have been expanded and improved to the extent that greater numbers than ever before are attending. The programs of the scientific sections now include some of the world's greatest medical scientists as participants. As a result of this, more and more industrial exhibitors are attracted to these meetings and are beginning to be aware of the great potential in our field. The time has come when we must make every effort to extend and expand individual and group study and research programs, in order to participate in state and national meetings with new and provocative exhibits and papers. When this is accomplished the opportunity to participate in programs of related fields will be readily open to us. This has been clearly demonstrated during the past year, when your national organization was invited to exhibit at the American Nurses Association's National League for Nursing, American Medical Association's Scientific Assembly in Atlantic City and the American Hospital Association's annual meeting, where in addition to our exhibit our Executive Secretary participated as part of a panel to discuss the "Allied Professions in Hospital Services." This in turn has been a part of this year's program at this meeting.

PROVIDING BETTER AND MORE COMPLETE FOOT HEALTH SERVICES. The development of our practice acts has been phenomenal, when we consider the short space of time that has passed from the enactment of the first laws governing our practice to the present day, when all states have laws, nearly two-thirds of which enable us to practice to the full extent of our training; when medical service plans are beginning to recognize the helpful place of the podiatrist-chiropodist in their programs; when we realize that it is through the dedicated efforts of individuals and state societies these programs are rapidly expanding, having its effect felt throughout the nation.

The time has come to be ever alert to the responsibility that we have to the public by improving our position in these areas in order to provide the most adequate service, to which they are entitled. Here we must immediately activate our program of labor relations. We must develop closer liaison between the individual, division, state and national organization, to work in harmony, as a team for our ultimate goals.

*OUR STATUS IN THE ARMED FORCES AND VETERANS' ADMIN-*ISTRATION. Let us briefly review our position in these areas. How can any of us forget the heart-breaking efforts of many individuals and officers of this association that laid the groundwork for our participation in these vital areas. The discouragements that each of us felt when the need for our services which was so obvious, were denied the men under arms, with the exception of

the Navy. How proud and thrilled we were when it was announced, just a few years ago, that the Profession now held commissioned status in the Army and the Air Corps. And now the Veterans' Administration are calling on us to fill a need that is so important in the rehabilitation of the veteran.

A clear indication as to the value of our services is visually demonstrated at this meeting. The Army proudly presents its exhibit "The Podiatry Service in the Army Medical Corps," at our scientific assembly. This exhibit has been shown at a number of important meetings in this country. For the second time within one year, closed circuit color television, on the Podiatry Service at Walter Reed Army Medical Center, has been produced. A kinescope film was made especially for this meeting. Young graduates in podiatry-chiropody can today find new careers in federal service that were unheard of a short time back. It is quite possible that within a few years we will be unable to fill the demand of public and private agencies for full-time podiatric care.

MEDICAL AND HOSPITAL RELATIONS. We can all recall with pride the beginning of our formal participation in hospital programs, when Eliot P. Joslin, M.D., established the first chiropody clinic at the New Deaconess Hospital in Boston. The value of such clinics in hospitals and medical centers throughout the nation is now common knowledge to us, but unfortunately its full service is not recognized by the medical profession and the public in general. One of our most distinguished medical leaders, Charles W. Mayo, M.D., put it quite bluntly (quote) "The (Podiatry-Chiropody) profession—did not, and UNFORTUNATELY, *still does not* receive the attention it merits—that doctors of medicine, myself included, have paid too little attention to the feet in their relationship to the condition of the patient—I extend to you my congratulations (our profession)—an integrated group which has filled a great need in the interest of the public health—" (unquote)

Your national organization has been fully cognizant of this, and a few years ago began a program of medical and hospital relations, that this year is beginning to manifest itself. As reported earlier, the major medical organizations of America have invited us to participate in their programs. These organizations are responsible for the nation's health and set policy for the nation's practitioner and for the nation's hospitals. It is now your responsibility and mine as individuals and affiliated state societies, to improve this liaison, by more scientific developments and by more active participation in local and state medical and hospital programs.

As has been reported in the JOURNAL, reported at your regional meetings, and reported at the house of delegates, there is now available approved methods and policies, developed by your national committees on medical and hospital relations, that will help you. It is your responsibility to participate in this activity with your divisional and state committees. It is our obligation to the public welfare to acquaint medical groups and hospitals with our status, and the part that we can play in their programs in the public interest.

LIAISON WITH FEDERAL AND STATE AGENCIES. It is important that you are reminded of the many developments in federal and state programs affecting the nation's foot health. This past year we have participated in nearly two hundred pilot surveys in thirty states as part of the President's Youth

Fitness Program. This must be continued and broadened. Your national organization is now a participating member of the government's Geriatric program. We must extend our efforts in the field of the aging and the health care of the aged. This is another example of a major opportunity that we have to be of invaluable service. Nearly every community in America has committees on aging now being organized. They will welcome our participation.

PUBLIC RELATIONS AND PUBLIC EDUCATION. The time has come for a definition of terms. Public relations and Education is NOT—I REPEAT *—IS NOT,* PRESS AGENTRY! Just having write-ups in newspapers and magazines will not develop the relations with the public that is needed, nor will this necessarily offer any educational benefits to the public. Outstanding authorities in this field have stated time and again, when each and every member of our profession will conduct himself in a manner that will reflect his dedication to his patients, his community and his colleagues, then one might say our public relations has begun. When it can be reported that individually or collectively that we have contributed to the advancement of medical science, then it can be said we are developing public education. A brief search in the record will reveal that many states and certainly your national association has made a good start in this direction this year. As has been reported, a number of national periodicals have carried our messages. Your new Audio-Visual Catalog offers a comprehensive list of materials for professional and public education and information. The request for this catalog and for the materials listed, from leading editors, hospital administrators, medical schools and libraries has been overwhelming. Let us remember that each of us must do our part, in our own area. *The hired expert can only direct us.*

THE FUND FOR PODIATRY-CHIROPODY EDUCATION. We have established this fund to provide monies for our educational institutions, to improve and augment the faculties, physical facilities, and to provide for research. Unless we, the rank and file of the profession, provide the nucleus of the money needed we cannot expect the financial grants that would be forthcoming from interested foundations in education and industry.

VOCATIONAL GUIDANCE PROGRAM. I am sure that all of us are aware of the tremendous program begun by our national committee in recruitment—the extensive distribution of films, pamphlets, brochures and exhibits—the intensive speakers' programs that were started nationally through the service clubs. Although the results may be slow in manifesting themselves I am certain that within three years the effectiveness of this committee's efforts will be demonstrated. Here again each of us must increase our efforts, for without new blood, all of our gains are for naught.

I BELIEVE—I believe, that the time has come when we must accept, not assume, our status. This statement was made by several of our Past Presidents. There is no need now for apology. We have the knowledge and we have the self-respect. We are being called on to fill a gap in medical science—this we will do.

I believe that we have an obligation to our predecessors who have given their lives to the establishment of this noble art. I believe that this obligation extends to our teachers, our families and above all, the general public.

WHAT WILL OUR PROGRAM BE FOR THE COMING YEAR? Although every facet of this organization is important, every committee will be active. As your President I must continue the recommendations of our sage and wise Past Presidents and members of the official family who agree that the following must be done:

1. Student recruitment and vocational guidance.
2. Improve and broaden out educational backgrounds.
3. State legislative programs, participation in medical service plans, and labor relations.
4. Broaden our medical and hospital relations.
5. Strengthen our public relations and education.
6. The development of the FUND for Education.
7. Last, but not least—every member will be kept up to date on important happenings on the national scene, and each state will improve its cooperation with its national organization.

I believe these things can be done. I believe that each of us can and will select those areas where our talents are best fitted. I believe that each division and state society should be cognizant of its responsibilities. I believe the national association should represent the membership as a whole for the good and welfare, and set policy at the national level, but that it is incumbent upon the affiliated state societies to cooperate to the fullest to carry these programs to the grass roots.

In closing may I read a phrase from an unknown author that has been an inspiration for the past twenty-eight years?—I BELIEVE

"EVERY MAN GIVES HIS LIFE FOR WHAT HE BELIEVES. EVERY WOMAN GIVES HER LIFE FOR WHAT SHE BELIEVES. SOMETIMES PEOPLE BELIEVE IN LITTLE OR NOTHING; NEVERTHELESS, THEY GIVE THEIR LIVES FOR THAT LITTLE OR NOTHING. ONE LIFE IS ALL WE HAVE, AND WE LIVE IT AS WE BELIEVE IN LIVING IT, AND THEN IT'S GONE. BUT TO SURRENDER WHAT YOU ARE, AND LIVE WITHOUT BELIEF, THAT'S MORE TERRIBLE THAN DYING, MORE TERRIBLE THAN DYING YOUNG."

Marvin W. Shapiro, D.S.C.

ANNUAL MEETING 1959

Preliminary Report

The 47th Annual Meeting of the Association, August 27 through September 1, 1959, Waldorf-Astoria Hotel, New York, N.Y., was the largest in the Association's history. Registration by members, family and guests exceeded any previous year, as did the number of industrial and scientific exhibits. More than 120 individuals participated in the Scientific Sessions.

The House of Delegates revised very considerably the Constitution and Bylaws of the American Podiatry Association and the National Association of Chiropodists. The revisions provide for a Speaker and Assistant Speaker for the House of Delegates and a Board of Inquiry when necessary. The Executive Council, under another provision, becomes the Board of Trustees. The Council on Education will consist of ten members, seven elected by

the House of Delegates for overlapping three-year terms, two nominated by the American Association of Chiropody-Podiatry Colleges and one nominated by the Federation of Chiropody-Podiatry Boards and the three nominees to be approved by the House of Delegates for overlapping terms of three years.

The House of Delegates approved by the necessary two-thirds majority the proposition to increase the annual assessment per member for dues to the national association from $30.00 to $40.00 effective June 1, 1960. A $10,000.00 fund was established for the production, distribution and sale of public educational and informational materials. The reserve funds of the Association were authorized to be separated into a Depreciation Reserve Fund and a General Reserve Fund. These Funds may consist only of U. S. Government Securities or U. S. Government insured savings deposits. The General Reserve Fund must at all times amount to no less than $30,000.00. The Depreciation Reserve Fund will initially be $34,182.66. A Budget for the fiscal year 1959-60 in an amount not to exceed $216,900.00 was adopted. This provided for deficit spending not to exceed $5,900.00. Eleven life memberships were voted.

Dr. Marvin W. Shapiro of Toledo, Ohio, was installed as President and Dr. Marvin D. Marr of Cedar Rapids, Iowa, was elected President-Elect. Dr. Robert Shor, Los Angeles, California, and Dr. Benjamin C. Mullens, Binghamton, N. Y., were re-elected and elected, respectively, as Vice Presidents. Dr. Harry I. Horowitz, Astoria, L. I., N. Y., was re-elected and Dr. William A. Edwards, Reno, Nevada, elected to the Board of Trustees for three-year terms. Dr. Leo N. Liss, San Francisco, California, and Dr. Jonas C. Morris, Audubon, N. J., were elected Speaker and Vice-Speaker, respectively, of the 1960 House of Delegates. Dr. Milton H. Gennis, Tulsa, Oklahoma, was re-elected and Drs. Edward N. Barron, Little Rock, Arkansas, and Raymond K. Locke, Englewood, N. J., were elected to the Council on Education for three-year terms. Dr. Gordon R. Tobin, Twin Falls, Idaho, the nominee of the Federation of Chiropody-Podiatry State Boards, was approved by the House of Delegates for a three-year term on the Council on Education. Dr. Charles R. Brantingham, Long Beach, California, and H. Darrel Darby, Huntington, West Virginia, were elected for three-year terms to the Board of Trustees of the American Foot Health Foundation.

The recipients of the William J. Stickel Annual Awards for Research in Chiropody (Podiatry) were announced as follows: First Award, W. A. Pepin, D.S.C. (co-author F. W. Kasch, Ph.D.); Second Award, H. C. Goldberg, M.D.; Third Award, Thomas R. Amberry, D.S.C.; Fourth Award, Earl G. Kaplan, D.S.C.; Fifth Award, Milton E. Ashur, D.S.C. (co-author Reginald H. Farrar, M.D.); Honorable Mention, A. E. Cole, D.S.C., D. A. Schubert, D.S.C., Charles E. Krausz, D.S.C., Milton Henenfeld, Pod.D.

The following Awards were made for Scientific Exhibits: Individual—Gold Medal, Milton E. Lewis, D.S.C., F.A.S.C.R.; Silver Medal, Seymour H. Blau, D.S.C. Individual (supported by Grants-in Aid) —Gold Medal, Milton R. Lewis, D.S.C.; Silver Medal, Milton E. Ashur, D.S.C.; Bronze Medal, Benjamin Feldman, D.S.C.; Bronze Medal, Reginald H. Farrar, M.D. and Milton E. Ashur, D.S.C. Institutional —Gold Medal, California College of Podiatry; Silver Medal, Ohio College of Chiropody; Bronze Medal, M. J. Lewi College of Podiatry; Bronze Medal, Civic Hospital. Organizational—Gold Medal, American College of Foot Orthopedics; Silver Medal, Podiatry Staff, Cerebral Palsy Center, Roosevelt, Long Island; Bronze Medal, Edward Ganny, D.S.C.; Bronze Medal, Council on Pharmacy. Special—Gold Medal, Jersey City Medical Center and Seton Hall College of Medicine; Silver Medal, Cleveland White, M.D. Foot Health Exhibits, High School Science Fairs—Silver Medals were awarded to the following: Joel Feder, Robert E. Sherman, Roberta Barnes. Honorable Mention—Veterans Administration, White House Conference on Children and Youth and Raymond K. Locke, D.S.C.

It is estimated that more than 2500 persons attended the sessions, meetings and exhibits. A preliminary, unverified count indicates that 1311 podiatrists-chiropodists, 274 members of related professions and associations, and 275 Industrial Exhibitors and Advertising Representatives were registered.

A further report will appear in a subsequent issue.

WASHINGTON REPORT

GOLDEN ANNIVERSARY WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH

General Background

The American Podiatry Association and the American Foot Health Foundation are two of nearly 500 national organizations affiliated with the Golden Anniversary White House Conference on Children and Youth. Seven thousand delegates will receive invitations from the President of the United States to attend the Conference which is scheduled for March 27-April 2, 1960 in Washington, D. C. This is the sixth such decennial conference held in the United States since President Theodore Roosevelt called the first in 1909.

The Council of National Organizations on Children and Youth of the Golden Anniversary White House Conference on Children and Youth is the framework joining the several hundred organizations of widely different size, interests and character. Shared by all is a concern for the well-being of children and youth that is expressed through each organization's own programs and activities.

The Council of National Organizations is one of three major groups functioning in preparatory work for the Conference. Others are the National Council of State Committees on Children and Youth, made up of Governor-appointed citizen committees in every state and territory and the Interdepartmental Committee on Children and Youth, representing 34 agencies of the Federal Government.

Combined, they already have brought several million Americans into pre-Conference activity, taking national inventory of the needs, services and problems of children and youth, and furnishing this information to White House Conference headquarters in Washington.

Conference Follow-up

The purpose of the Golden Anniversary White House Conference, as stated in its theme, is "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity."

Therefore, "action support in the follow through phase after the Conference" is a primary objective of planning even at this stage, according to Mrs. Rollin Brown of Los Angeles, chairman of the President's National Committee for the Conference. President Eisenhower is national honorary chairman and Arthur S. Flemming, Secretary of Health, Education, and Welfare, is honorary vice-chairman.

National organizations can make a special contribution to Conference follow-up. Via their already existing networks of state and local units, their membership will be in a position to inspire general citizen action, starting next April, to meet the needs of youth revealed through the Conference.

In so doing, each organization will be furthering its own aims on behalf of children and youth. Each can be thinking now about how it will shape its own assignment to see that new services, new techniques and new approaches come into being in line with the Conference's inspirational theme.

Conference Program

"The broad concerns of every national organization affiliated with the Golden Anniversary White House Conference will be included in some phase of the Conference program during the week of March 27-April 2, 1960," according to Dr. Philip S. Barba of Philadelphia, chairman of the

Committee on Program for the White House Conference on Children and Youth.

Dr. Barba explains that the program format for the Conference will deal with youth from an interdisciplinary approach, rather than from a specialist approach.

Each delegate will be assigned to a workgroup of not more than 30, including lay and professional persons interested and active in fields relating to children and youth. The subject to be discussed in each workgroup will cut across discipline lines so as to stimulate new perspective and broaden knowledge by exchange of information and experiences.

Youth at the Conference

National organizations will nominate 1700 of the total of 7,000 persons to be invited to the Golden Anniversary White House Conference, March 27-April 2, 1960, with each organization allotted a minimum of two nominees.

Of the 1700, 300 are to be youth representatives aged 16 through 21. An additional 200 are to be young adults between the years of 21 and 30.

This request to national organizations to nominate youth delegates to the Conference reflects an over-all formula which will build youth representation into the Conference.

The young people will be treated as full scale delegates, taking their place beside adults in workgroups dealing with every current problem facing American children and youth.

Each member organization in the Council of National Organizations on Children and Youth is being asked if it has youth or young adult members. If so, the organization will be asked to indicate how many of each and whether the organization wishes to receive invitations in either or both age ranges.

National Organizations to Evaluate Own Programs for White House Conference

The White House Conference is receiving reports from national organizations represented in the Council of National Organizations on Children and Youth evaluating their own programs in terms of the *future*. Each organization has been asked to identify some of its major unsolved problems, some of the areas in which it plans to give added future emphasis, and to formulate possible recommendations addressed to itself and others. These evaluations will be synthesized and edited as part of a volume of national organization material to be furnished to delegates as part of their background for the White House Conference.

September Meeting Scheduled

All members of the Council of National Organizations on Children and Youth of the Golden Anniversary White House Conference on Children and Youth have been invited to send two representatives to a meeting of the Council which will be held September 21 and 22 at the Department of Health, Education, and Welfare in Washington, D. C. Plans for participation of national organizations in the White House Conference will be discussed and developed at that time.

"Meditation is not a flourishing of a man's wit but hath a set bout at the search of the truth."

Thomas Hooker, 1637

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. J. PICKETT, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

REMOVAL OF HYPERTROPHIED FIBULAR SESAMOID, SECOND METATARSAL HEAD AND HEAD OF PROXIMAL PHALANX

Mrs. A. M., aged 58, presented herself at the hospital with a nucleated tyloma under the second metatarsal head, a clavus under the fibular sesamoid, and a hammertoe of the second with a clavus on the dorsal of the proximal phalangeal joint.

Roentgenograms showed enlarged second metatarsal head, a displaced fibular sesamoid, and a deformity of the second toe at the proximal phalangeal joint.

Urinalysis: Color, Straw; Alb., neg.; S. G. 1.020; Sugar, neg.; acetone, neg.; W.B.C. occ'l.; R.B.C. neg.

Blood Count findings: Hemoglobin 81%, W.B.C. 9,600, R.B.C. 4,330,000. Differential: Non seg. 1; Segs. 58; Eosins. 3; Lymphs. 36; Monos. 2.

Preoperative blood pressure 110/80, and oral temperature 98°.

The preoperative medication was Nembutal®[1] gr. iii and 100 mg. Demerol®[2] one hour preoperatively.

After aseptic procedure the patient was given Pentothal®[1] Sodium.

Operative technic was as follows: A seven centimeter incision extending from the distal one-third of the 1st and 2nd metatarsal interspace to the distal end of the proximal interphalangeal joint was made. The extensor tendons were retracted over the second metatarsophalangeal joint, the capsule incised, and the second metatarsal head removed. The capsule of the second interphalangeal was incised and the head of the proximal phalanx was removed and the end of the shaft rasped smooth. The fibular sesamoid was removed by enucleating it from the lateral tendon of the flexor hallucis brevis. Eight skin clamps were used to close the incision. Sterile Telfa®[3], dressings and an ace bandage were used to dress the wound.

The patient was given Nembutal grs. 1½ h.s. as a sedative, and the analgesic was Demerol 100 mg. q 6 h. p.r.n.

Fig. 1 Pre- (left) and postoperative radiograph.

Postoperatively the treatment was as follows: On the fifth day the outer dressing was removed and sterile gauze dressings applied. On the eighth day the sutures were removed, Tn. Merthiolate®[4] used and sterile gauze dressings applied. On the 10th, 16th, 22nd, 27th and 29th postoperative days sterile gauze dressings were used. On the 31st whirlpool was used and sterile gauze dressing applied. On the 36th day whirlpool was used and the patient dismissed.

George A. Shore, D.S.C.

Comments: It is not uncommon in cases of this nature to remove the fibular sesa-

®[1]Abbott ®[2]Winthrop ®[3]Bauer & Black ®[4]Lilly

moid. However, it is rare that the head of the 2nd metatarsal head be removed to aid in the realignment of the forefoot.

More frequently when this procedure is necessary the more common procedure is to amputate the metatarsal head at about the distal 1/3 of the metatarsal shaft rather than just the metatarsal head.

This case is being included in that it offers a good example of alteration in surgical judgment.

N. J. P.

DORSAL TENDON RESECTION AND CAPSULOTOMY FOR AN OVERLAPPING FIFTH TOE

Miss R. M., aged 11, presented herself at the office with the fifth toe of the left overlapping the lateral aspect of the fourth toe. She had had a similar experience with the right foot the previous year and it had been operated successfully.

Urinalysis: Sp. Gr. 1.1018, PH 4.5, albumen, glucose, acetone, and others negative. Microscopic cells & crystals normal.

Bleeding time 2 minutes. Coagulation time 4 minutes.

After aseptic procedure 1½ cc. Xylocaine®[1] 2% was used as a field block.

Operative technic was as follows: A dorsal lineal incision approximately 3 centimeters long was made over the medial side of the fifth metatarsal shaft and head. The extensor digitorum longus tendon was exposed and approximately ½" removed. A transverse capsulotomy was done and the shortened soft tissue incised. The incision was closed with two single interrupted 000 dermal sutures. A sterile dressing was applied over the wound, and the toe bound in a slightly overcorrected position.

The patient was given children's size aspirin 1 q. 3 h., told to elevate the foot and use an ice pack for the first night.

Postoperative treatment was as follows: On the third day Tr. Merthiolate®[2], sterile gauze and a dorsal felt pad to maintain flexion with keyhole adhesive strap was used. On the seventh day the sutures were removed, Tr. Merthiolate, and the abovementioned gauze and pad used. The fourteenth day and for a six-week period following the surgery the keyhole strap was continued weekly to maintain overcorrection. The patient was discharged at the end of the six weeks.

The patient was home for twenty-four hours. Ambulation was permitted on the second day. The recovery was uneventful and the toe in normal position.

William F. Jeffery, D.S.C.

Comments: Overlapping 5th toes usually are congenital in nature and need not be bi-lateral. This condition responds better to surgical intervention at about this patient's age rather than as an adult and the prognosis is in proportion to the age of the patient.

Early splinting of the toe at the age of 2 or 3 years frequently produces good results. However, when the toe becomes fixed in the overlapping position, surgery seems to be the only solution.

N. J. P.

®[1]Astra

®[2]Lilly

"What you are speaks so loud I can not hear what you say."

Emerson

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Vi-Dom-A™ Buccal Tablets

Description: Each tablet contains either 75,000 or 150,000 U.S.P. units synthetic vitamin A in a pleasantly flavored, candy base.

Indications: Acne vulgaris, xerophthalmia, leukoplakia vulvae, senile skin, dry skin, oral leukoplakia, lichen planus, candidiasis, ichthyosis, lichen pilaris, hyperkeratosis and other vitamin A deficiencies.

Administration: One tablet daily placed in the mouth and allowed to dissolve slowly, insuring constant bathing of the buccal mucosa and more effective systemic utilization. Repeat dosage if necessary. Tablets may be chewed and swallowed if necessary.

Supply: Bottles of 25 tablets in two strengths of synthetic vitamin A, 75,000 U.S.P. units and 150,000 U.S.P. units. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

Vi-Dom-A-C™ Pillettes

Description: Each small spherical pillette contains 50,000 U.S.P. units vitamin A and 250 mg. vitamin C (ascorbic acid).

Indications: Acne vulgaris, senile skin, dry skin.

Administration: One pillette daily, repeated if necessary.

Supply: In bottles of 25 and 100. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

Vi-Dom-A® Creme (pH 6.8)

Description: Contains 100,000 U.S.P. units synthetic vitamin A per oz. in a vanishing creme base.

Indications: Acne, plantar warts, senile skin and rough, dry skin.

Administration: Gently massage into affected areas in liberal amounts two or three times daily.

Supply: In 1 oz. tube and 2 oz. and 1 lb. jars. Prescription only. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

Vi-Dom-A® Pillettes

Description: Each pillette contains 25,000 or 50,000 U.S.P. units synthetic vitamin A in a chewable, small, spherical water-miscible pillette.

Indications: During infancy, pregnancy and lactation, when vitamin A requirements are particularly high, acne vulgaris, xerophthalmia, leukoplakia vulvae, senile skin, dry skin, ichthyosis, lichen pilaris, lichen planus, leukoplakia, prostatovesicular backache and other vitamin A deficiencies.

Administration: One or more tablets daily as required.

Supply: Pillettes of 25,000 U.S.P. units and 50,000 U.S.P. units in bottles of 100. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

CIRCULATORY SYSTEM

Neurotrophic Ulcers of the Feet, P. J. Kelly and M. B. Coventry. J.A.M.A. 168: 388-93, 1958.

The case histories of 47 patients with ulcers of neurotrophic origin, who had been treated at the Mayo clinic between 1946 and 1956, were studied, together with follow-up data obtained through questionnaires. Diabetic neuropathy was found to be the most frequent cause; tabes dorsalis proved to be the cause in only one case. One case of trophic ulcer of the foot which followed herpes zoster seemed to be the only case on record. The commonest site of the ulcer was the plantar aspect of the foot. Other frequent areas were the medial aspect of the plantar surface of the hallux, the lateral aspect of the fifth metatarsal head, and the tips of the toes. Thick, heavy callosities always preceded ulcers on the surface of the metatarsal heads. In 46 patients 59 plantar ulcers were noted; the remaining patient had an ulcer on the dorsum of the forefoot. Myelodysplastic neurotrophic ulcers were found on the tips of the toes. The diabetic neurotrophic ulcers were located almost invariably in the region of the metatarsal heads and medial aspect of the plantar aspect of the hallux.

The architecture of the foot seemed to be a mechanical cause of ulcer. Usually, a broad, splay, or metatarsus latus type of foot with hammer toes, hallux valgus, and prominent metatarsal heads was the type. The neurotrophic ulcer has a punched out, circular appearance, and is associated with infection and occasionally is pregangrenous. Significant diagnostic findings are changes of a degenerative nature in the foot, with peripheral sensory impairment, unexplained, excessive bony proliferation, periosteal thickening affecting a site remote from the ulcer, proliferation and sclerotic changes at the first metatarsophalangeal joint and the midtarsal joint.

Conservative therapeutic measures as adjunct to surgery include control of the metabolic problem in diabetes, and wearing of proper shoes with well-placed pads and bars. Numerous surgical procedures were used on these patients. Removal of the toe or of the metatarsal head only, in some cases of ulcer under the metatarsal head, was often successful. It was performed as a two-stage procedure. In cases long existent, recurrent, or even multiple, below-knee amputation was sometimes necessary. Transmetatarsal amputation performed in two diabetic patients proved unsuccessful; ulcers have recurred for 10 years. In 3 of 4 patients cross-leg pedicle skin grafts failed. Simple debridement was successful in elderly diabetics whose symptoms were of short duration, if activities were restricted and properly fitted shoes were worn.

Elderly diabetics should receive prophylactic treatment to protect the region of the metatarsal heads and, possibly, routine x-ray examination. Those having neurotrophic ulcers of only a few months duration should have the ulcers debrided and calluses trimmed. Amputation at the lowest level possible may be the only treatment of patients in the third decade of life who have myelodysplasia and prolonged, recurrent neurotrophic ulcers.

MUSCULOSKELETAL SYSTEM

Osteomyelitis of the Calcis Following Triple Arthrodesis, C. R. MacKay and I. S. Mauer. Amer. J. Surg. 96: 708-10, 1958.

Fusion of the talocalcaneal, calcaneocuboid, and talonavicular joints is frequently performed in treatment of comminuted, compression type fractures of the os calcis; or fusion may be performed later in treatment of the disabling traumatic arthritis which often follows damage to the articular cartilages. This procedure often produces a stable, pain-free foot. On the other hand, development of osteomyelitis is not infrequently an after-effect.

Chronic osteomyelitis of the calcaneus is characterized by slow but progressive development of concomitant infection of the surrounding soft tissues, by formation of sinus tracts, and prolonged resistance to cure. Osteomyelitis of the os calcis, despite modern antibiotic therapy and surgical schemata remains a disabling, long drawn out process, and may finally end in amputation. During the past 10 years, 12 cases of osteomyelitis of the os calcis were treated; 6 cases followed triple arthrodesis; one followed reduction of a fracture with screw fixation. Blood supply was decreased by the fracture, by surgical trauma, by stripping of soft tissues, and other factors in the arthrodesis. The presence of numerous raw surfaces of ischemic bone provided a site of minor resistance to infection.

Specific antibacterial drugs were used locally and systemically, but failed to eradicate the disease process. Various surgical procedures were used: multiple debridement, curettement, saucerization, partial and complete excision of affected parts, and various minor surgical measures. The usual sterile preparations were used preoperatively and during surgery, and antibiotics immediately after operation. Four of the 12 patients finally required amputation. Often after years of suffering and after many operations and treatments, an amputation is necessary to provide a pain-free and useful life in such patients.

Morton's Toe: Intractable Pain About the Fourth Metatarso-Phalangeal Articulation, R. M. O'Brien. Missouri Med. 55: 586-89, 1958.

Metatarsalgia, a dull aching pain in the sole of the foot in the metatarsal area, is relieved by rest and use of arch supports. Morton's toe is a spasmodic, laminating, and radiating metatarsal pain usually affecting the fourth toe and its metatarsal articulation. Use of arch supports and metatarsal bars bring no relief. In two reported studies of a total of 50 cases, the etiology of the pain was said to be a neurofibroma type of lesion involving the most lateral branch of the medial plantar nerve, that is, the branch between the third and fourth metatarsal head. Two later studies of a total of 29 cases reported the same findings. Surgical removal brought immediate relief of pain. The author reports 25 additional cases with similar findings and results. The diagnosis had been made on the basis of subjective complaints, and a failure of conservative measures to relieve the pain.

There are few physical findings. The foot may appear normal, or it may show a spreading of the metatarsal arch, and calluses underlying the metatarsal head. In some cases there is a localized tenderness in the web between the third and fourth toes, and in others a diminished sensation along the borders of these toes. A history of intermittent, recurring pain in that metatarsal region or in the fourth toe is most significant. That a woman patient will stop wherever she happens to be, to remove the shoe and rub the foot, is considered pathognomonic of a neuroma.

Conservative therapy should be tried first—rest, and use of arch supports and metatarsal bars. The operative procedure is: A dorsal web-splitting about 1½ inches

long is done between the third and fourth toes, and dissection carried down almost to the plantar aspect. Good exposure is provided by use of a mastoid type of retractor placed deeply in the wound. Pressure is applied to the sole of the foot, raising the lesion up between the metatarsal heads. The neuroma is dissected proximally and posteriorly until the normal nerve is encountered. This can be done under local anesthesia, but it is more easily performed under general anesthesia, with use of a tourniquet.

Congenital Curly Toes: An Investigation into the Value of Treatment, R. Sweetnam. Lancet 2: 398-399, 1959.

This deformity is a mixture of adduction and flexion, principally at the terminal joint, but may also be in the proximal. It is combined in severe cases with rotation of these joints, so that the nail comes to lie towards the lateral side. Two or three of the middle toes may be affected, and often both feet are involved.

Congenital deviation of the third and fourth toes, more common in the former, was studied in a group of 50 feet; about half of them had been treated and the other half not treated. The method of treatment used was the over-and-under strapping, continued for many months. It was started in all but three cases before the age of two. The children studied averaged 13 years of age. Growth of the crooked toes had not increased the deformity. About 25 per cent showed some improvement, but these were equally from the two groups, treated and untreated. Eleven of the children (22 per cent) had members of the families with similar affection. The curly toes produced no symptoms.

The study showed that over-and-under strapping has no significant effect. It was felt that no form of treatment would have been worthwhile, since one-fourth of the untreated cases improved, and none of the remainder deteriorated. It seemed unlikely that any troublesome symptoms would arise in adulthood. If the curly toes did become painful, they could be straightened by a simple operation. If these facts were explained to anxious parents, much time and valueless effort in treating a condition which requires no treatment, could be saved.

Hallux Rigidus in the Adolescent, L. Kessel and G. Bonny. J. Bone & Joint Surg. 40B: 669-73, 1958.

Nine patients, aged 11 to 21, with hallux rigidus (bilateral in one patient) which failed to respond to conservative therapy, were operated on, and were followed-up from 5 months to 4½ years. In all the affected 10 great toes, dorsiflexion at the metatarsophalangeal joint was limited but a good range of plantar flexion was maintained. Passive dorsiflexion of the joint was painful. The painful restriction of dorsiflexion was considered the final common factor producing symptoms in these patients.

In determination of the cause of such painful restriction of dorsiflexion, consideration must be given to the possible intrinsic disorders of the metatarsophalangeal joint, to the extrinsic factors acting on the joint, and possible combination of the two types of factors. In two patients there was radiologic evidence of osteochondritis of the head of the first metatarsal; whether primary or secondary could not be determined. However, extrinsic causes of hallux rigidus seemed evident, which suggested that "hyperextension" of the first metatarsal was the primary cause of this condition. One of the patients developed elevation of the first metatarsal after onset of symptoms, but in most of the patients well-marked elevation of the first metatarsal was noted when the patients were first seen. A study of three adults gave further evidence that in

some cases such elevation is primary, and the joint disorder secondary.

Two patients had an "artificial" metatarsus primus elevation which was inadvertently produced at operation—one after osteotomy of the first metatarsal which was performed for hallux valgus; the other after triple arthrodesis, performed in the presence of muscle imbalance. This elevation of the first metatarsal in these two patients was followed by development of typical hallux rigidus, with painful restriction of the dorsiflexion of the metatarsophalangeal joint, attended by degenerative joint changes as shown on radiologic examination. Another patient, an adult, had marked depression of the first metatarsophalangeal joint, but with full dorsiflexion preserved.

When all conservative treatments have failed, including mobilization in below-knee plaster, so that pain and limited dorsiflexion continue, operation must be considered. The procedure used in these nine adolescents and also in one man aged 46, was an extension osteotomy at the base of the proximal phalanx of the great toe, thereby transferring the good range of plantar-flexion to a functionally useful range. The technic used was as follows:

A 2-inch curved incision was centered over the base of the proximal phalanx, the skin flap dissected up, and the phalanx exposed. A wedge based dorsally was removed from the phalanx, near the epiphysis, leaving intact both cortex and periosteum. After angulating the phalanx to close the gap, the skin was closed. Then the foot was immobilized in plaster, with the toe forced into extension. The wedge must be accurate in size and the plantar cortex intact. In 4 to 6 weeks the plaster is removed.

In all but one patient, symptoms were relieved, and painless functional activity restored. Dorsiflexion at the metatarsophalangeal joint was from 20 to 75 degrees. The total range of movement was increased in every patient. Dorsiflexion which was 5 degrees preoperatively increased to 44 degrees postoperatively, as demonstrated radiologically. The adult, a milk deliverer, returned to full-time work 10 weeks after the operation.

NERVOUS SYSTEM

The Great Toe Jerk, G. A. Ransome. Brit. M. J. 2: 548, 1958.

The great toe jerk is probably a movement of the extensor hallucis longus, that is, a "great toe dorsal spring reflex." It is more delicate than the ankle jerk and requires considerable practice to obtain with ease, even by the skilled neurologist. It may be found in most normal persons between the ages of 7 and 70; it is difficult to obtain in very young children. Eventually, it may become a part of routine physical examinations.

The jerk is useful an an objective sign in disk lesions between the fourth and fifth lumbar vertebras, since it is abolished early in this disease—even before symptoms of weakness and of sciatic radiating pain appear. This reflex is useful in detecting peripheral neuritis, for example, in such diseases as typhoid fever, diphtheria, and diabetes, and in poliomyelitis.

The reflex is obtained by placing the index finger on the dorsal surface of the great toe's terminal phalanx, and downward pressure exerted gently until a feeling of elastic stretch is noticed. The examiner's finger is then struck with the hammer, using a wrist follow-up movement.

SURGERY

Skin Suture Marks, G. F. Crikelair. Amer. J. Surg. 96: 631-39. 1958.

Suture marks are scar tissue. They occur uncommonly on the eyelids, the palms and the soles. The skin of the back, chest, upper arms and lower extremities, as well as that of the lower one-third of the nose and cheeks, is more prone to such marks.

Non-absorbable sutures seem preferable, but the type of such material is unimportant. The method of using the stitch in skin closure is of greater importance.

Constructing tension depends on the tightness of the suture in relation to the tissue mass which is encompassed. When the suturing is too tight, local pressure can cause ischemia and tissue necrosis, leading to subsequent scarring, or suture marks. When too snug, tissues tied by the suture can become edematous, thereby increasing the tightness of the suture. The heavier the suture material, the easier it is to apply tension. The greater the bulk of tissue, the greater the amount of force applied to approximate the edges, and the more tissue there is to become edematous after suturing. Tensions are influenced, furthermore, by the direction of the incision in relation to normal skin tension lines, and by tension on the edges approximated. Keloid formation may be inherent in an individual. Stitch abscesses may indicate errors in skin preparation, or in operative technic, or are caused by too much tension; but they can occur also in most guarded situations.

The size of the suturing needle is important, because of the tearing of the skin. Size of the suture is next in importance. Small needles are required in plastic surgery, where fine scars and suture marks must be prevented. The effect of needle size, of suture size, and the number of days the sutures are left in place, was studied in 6 healthy men. These incisions were made to obtain rib cartilage for grafting The incisions were made at right angles to the skin surface; none of the skin was removed, only sutured. None of these subjects showed a tendency to keloid formation, and no stitch abscesses or reactions around the sutures occurred. Wounds were closed with No. 3.0 black and 5.0 white silk sutures.

Regardless of the size of the needle or of the suture, the greatest number of suture marks were found in all cases where the sutures were left in place for 15 days. In those with sutures left in for 7 days, no permanent marks occurred. Experimental studies were then made in laboratory pigs, which were subjected to various conditions, such as sutures placed at various distances from the cut edges, use of contaminated sutures, sutures left in place for 3 months. This produced only three isolated marks resembling suture marks. This indicated that suture marks occur only in human beings.

The experiment on the six men showed that if the sutures were removed early, regardless of any initial bunching of cut edges and slight reactions around the points of exit, no visible mark could be found. But when sutures were removed late, inevitably punctate marks and linear scar formation could be observed. It is believed that if tied without tension and the wounds immobilized, sutures removed by the seventh day will not leave suture marks; nor will there be suture marks even if they are tied with undue tension if removed by that time.

"The world belongs to the enthusiast who keeps cool."

Wm. McFee

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

CANADA

Alberta

The Sixth Annual Short Course in Clinical Medicine for Podiatrists will be held in Alberta, October 12-13, 1959. This course was arranged by the Department of Extension, University of Alberta, in cooperation with the Alberta Podiatry Association. Attendance is limited to practicing podiatrists in Canada.

The faculty consists of Gordon L. Wilson, M.D.; Robert A. Macbeth, B.A., M.D., M.Sc., F.R.C.S., F.A.C.S.; Hector E. Dugan, M.D., F.A.C.R.; Charles N. Gillis, B.Sc., Ph.D.

Subjects to be covered are: Toes for Corns—Soft and Hard; Infected Toe-Nails (two cases); Morton's Neuro-Fibroma; Sudden Occlusion of Arteries of the Lower Extremities; Chronic Obstruction of Arteries of the Lower Extremities; Sudden Occlusion of Veins of the Lower Extremities; Chronic Obstruction of Veins of the Lower Extremities; Radiation Hazards and Treatment; Atomic Fall-out; Muscle Relaxants and Ataraxics; Newer Drugs Affecting the Muscular-Skeletal System.

Communications should be addressed to: Director, Department of Extension, University of Alberta, Edmonton, Alberta.

British Columbia

On June 23, 1959, a banquet was held by the British Columbia Association of Chiropodists, paying tribute to Dr. Gorosh and presenting him with an expression of affection and appreciation for his leadership and guidance for more than thirty years. J. H. McDermot, M.D., C.M., a good medical friend of chiropody, spoke eloquently of his association with Dr. Gorosh over the years, as did many of the older members of the association.

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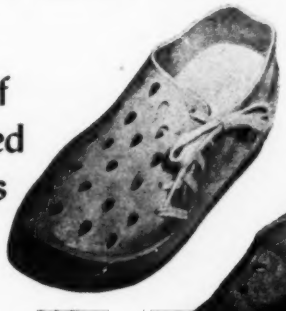

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—Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953.

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On behalf of the Association, Dr. D. B. Phelps presented a plaque, engraved as follows:

"In the history of every professional organization one man stands out as the pioneer—the one of few who, in the early days, had the courage, the ability, and the vision that to him, justified spending a lifetime in the service of his colleagues. To Jacob I. Gorosh, Doctor of Surgical Chiropody, the British Columbia Association of Chiropodists presents this plaque as a token of their affection and appreciation for his dedicated work over the years. May God bless him and spare him to us for many years to come. Vancouver, Canada. June, 1959."

MICHIGAN

Michigan Amends Chiropody Act

A bill clearing up ambiguous language in the Michigan Chiropody Act was signed into law by Governor G. Mennen Williams, June 5, 1959. The bill amends the exclusion clauses which define the practitioners who are excluded from meeting the provisions of the Act.

According to Legislative Committee chairman Dr. David Wright, Battle Creek, the principal benefit to be derived from the amendment to the Act is a strengthened definition of a chiropodist as a physician and surgeon. Dr. Wright emphasizes that the new wording will make it much more difficult for insurance carriers to refuse payment for services rendered by chiropodists in the future.

Michigan Board Takes Office

Dr. Donald Borchard, Saginaw, assumed the presidency of the Michigan Association during brief ceremonies at the beginning of the fiscal year in June. Other officers installed include: Dr. David Wright, Vice President; Dr. Bernard Levin, Secretary-Treasurer; Dr. Neil Jacobs, Sergeant-at-Arms; and Dr. Russell Seeburger, Past President.

Other members of the Board of Directors for the 1959-60 fiscal year include Drs. Albert Kalin, William Wagner, James

Simonds, John Didham, Fred Darby and Roland Perkins.

The new Board faces the complicated task of transferring the bulk of administrative activities of the Association to the recently established Association offices in Lansing. The Michigan group has employed a full-time executive secretary and stenographer and has also retained a legislative representative and legal counsel. Plans are now being formulated to expand the programs of legislation, public relations and organization.

Wayne County Provides Career Film

The Wayne County Chiropody Society has, for some time, made available the film, "Chiropody as a Career," to the Detroit schools. The film is filed, along with other visual aid materials, and is handled by school personnel much as any other visual aid materials would be. Wayne County Society president, Fred Darby, estimates that well over 5,000 students have seen the film in recent months.

PENNSYLVANIA

Western Division

The June meeting honored outgoing president Arthur Schultz and his officers. Plaque was awarded to Dr. Edward Bleirer as Man of the Year.

The following officers were installed for 1959-60: A. J. Colella, President; J. Keener, President-Elect; I. Smulczenski, Secretary; L. Schultz, Treasurer; L. Schultz, J. Carroll, E. Bleirer, F. Kindler, A. Wolf and A. Schultz, Council; R. Nicklas, J. Barker, B. C. Egerter and H. Stolzenberg, House of Delegates.

WEST VIRGINIA

At the June meeting of the Chiropody Society of West Virginia, the following officers were elected: Earl Sheff, President; D. Darby, Treasurer; Randall Taylor, Secretary.

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—Cooper, W. M., Am. J. Surg. 65:475, 1948.
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The Children's Bureau, U. S. Dept. of Health, Education and Welfare publishes a bi-monthly journal titled CHILDREN, subscription at $1.25 per year. A subscription blank may be had by writing to the U. S. Government Printing Office, Division of Public Documents, Washington 25, D. C. CHILDREN offers not only articles on health, welfare and education, but reports on "services that are working toward the improvement of child life."

LEGAL AND LEGISLATIVE

IOWA

Effective July 1, 1959, arrangements have been completed so that payment can be made directly to the chiropodists for certain services provided recipients of public assistance by the practitioner. Standards and regulations governing the amount and type of service for which payment can be made have been established.

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Adelaide Powers
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Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass., Sept. 25-27, 1959
Sheraton Plaza Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Mid-West Conference
Chicago, Ill., Mar. 25-27, 1960
Morrison Hotel
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Omaha, Neb., April 1-3, 1960
Sheraton-Fontenelle Hotel
Dr. Reid L. Cox, Gen. Chairman
409 Huron Bldg., Kansas City, Kansas

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Williamsburg, Va., Nov. 13-15, 1959
Williamsburg Inn
Dr. Leonard Kaplan
718 Court St., Portsmouth, Va.

Region Nine
(Florida)
Dr. Joy E. Adams
401 Florida Natl. Bank Bldg.,
St. Petersburg, Fla.

Region Ten
(Ala., Ga., Ken., Miss., Tenn.)
Louisville, Ky., Oct. 9-11, 1959
Brown Hotel
Dr. Chester A. Nava
4140 Shelbyville Rd., Louisville, Ky.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dr. W. C. Gigerich, Gen. Chairman
Arkansas Natl. Bank Bldg., Hot Springs, Ark.

Region Twelve
(Ariz., Cal., Nev., Utah)
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209 Post St., #412, San Francisco 8, Calif.

Canadian Podiatry Association
Toronto, Ontario, Sept. 5-8, 1959
King Edward Hotel
Dr. L. Hurwitz, Exec. Sec.
3017 Bathurst St., Toronto, Ont.

Idaho Podiatry Association
Sun Valley, Idaho
Sept. 11-13, 1959

Ohio College of Chiropody
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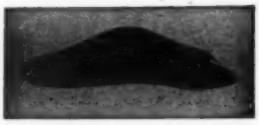

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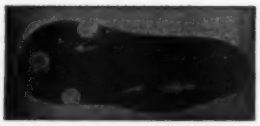

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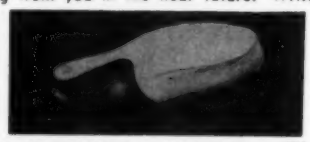

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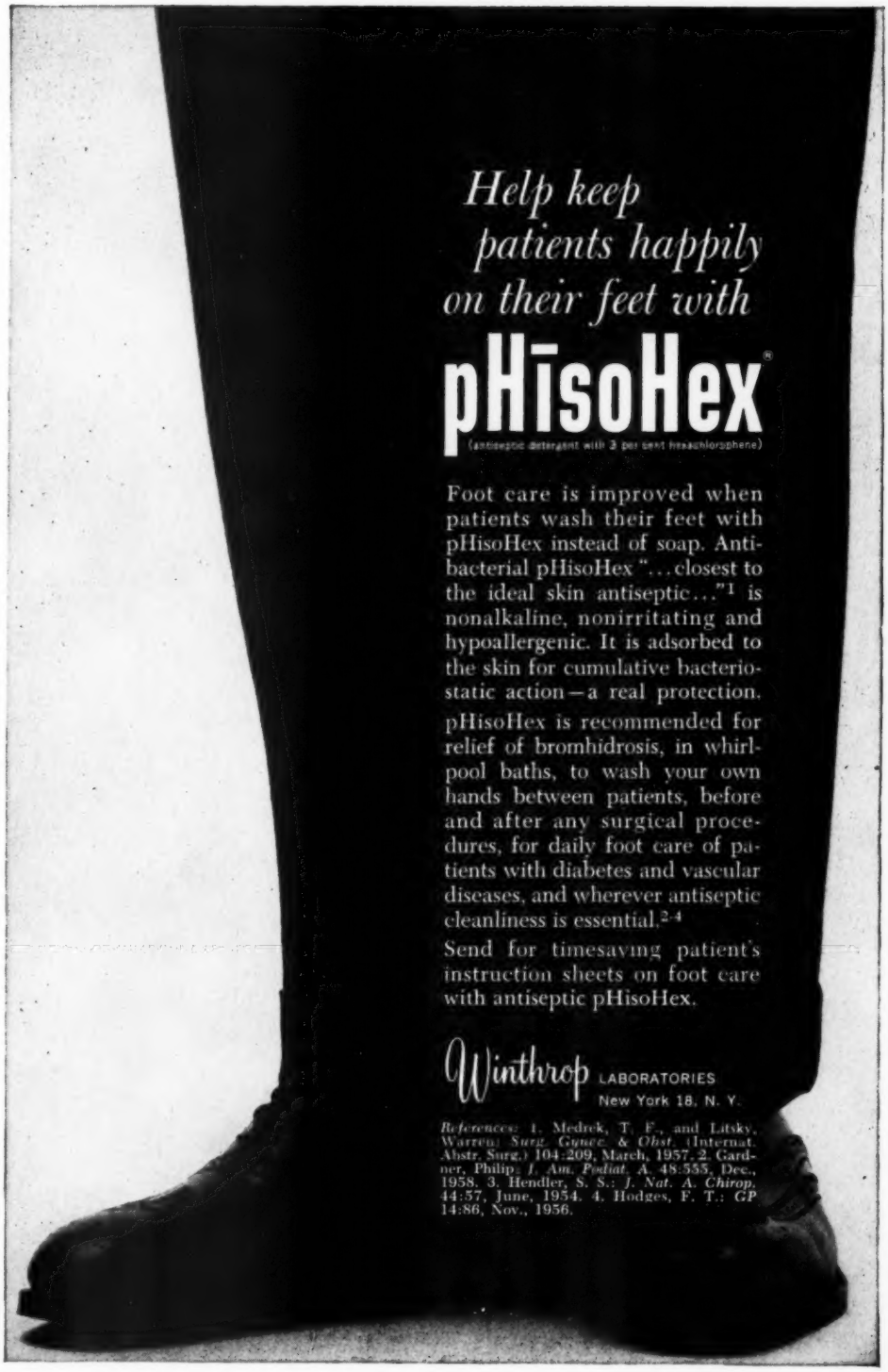
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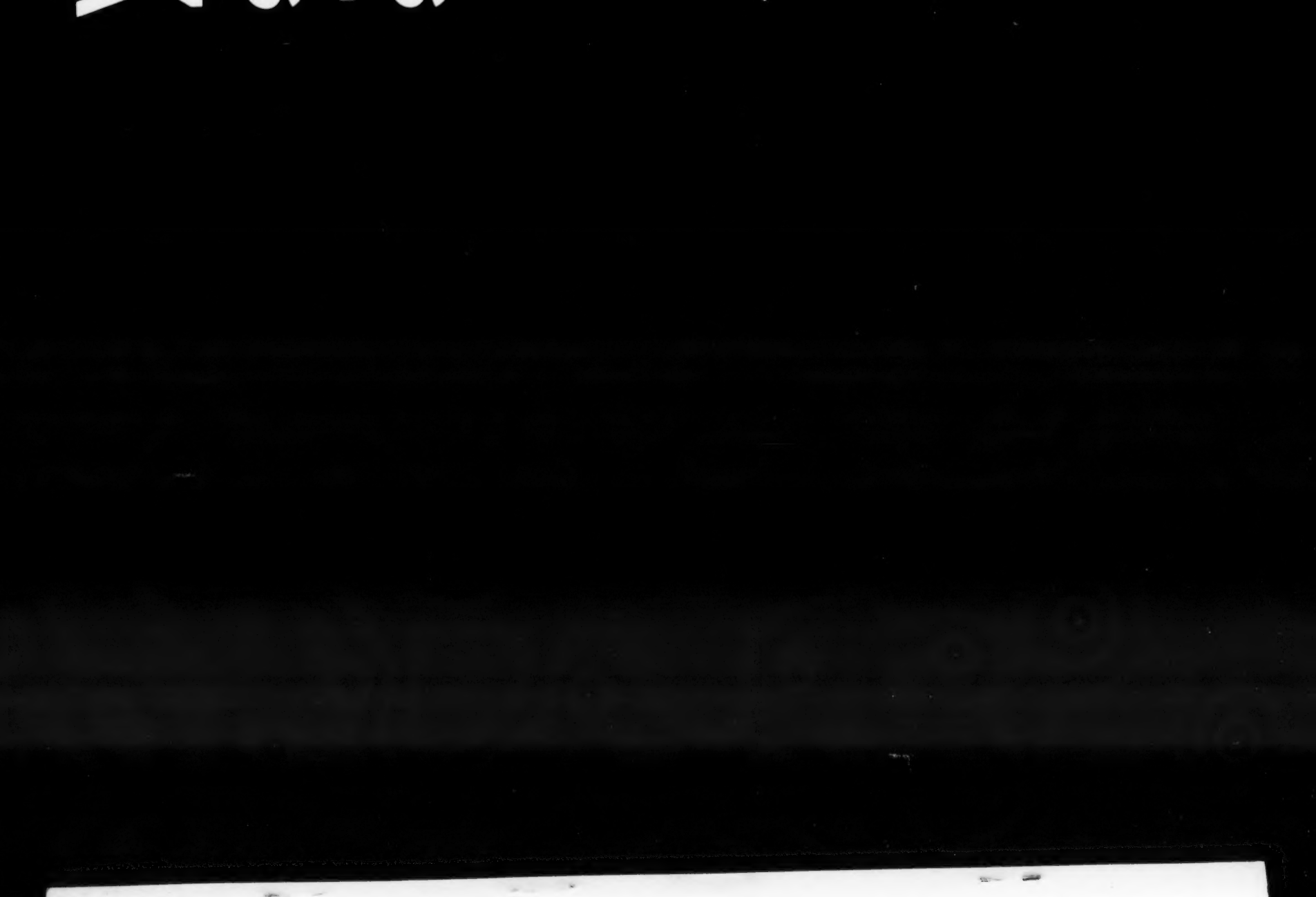
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